

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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Council unanimously adopts the Recommendation on Injury Prevention and Safety Promotion

On 31 May 2007 the Council unanimously adopted the Recommendation on Injury Prevention and Safety Promotion, a landmark in efforts to reduce accidents and injuries in Europe.

Officially adopted at the EPSCO (Employment, Social Policy, Health and Consumer Affairs) Council in Brussels, the Recommendation is the result of many months of hard work by all parties concerned. Both the efforts of the Finnish and German Presidencies in helping to move the process of adopting the proposal for a Recommendation along, and the support and commitment of the Member States for reaching agreement on it, deserve special acknowledgement.

The Council unanimously backed the argument of the Commission that the burden of injuries in Europe has to be reduced. “For the EU-25 we are facing 13 billion EURO injury-related healthcare costs each year. The good news is that most injuries are preventable at rather low costs. Studies indicate that one EURO spent will result in ten EURO savings in medical costs. With the adoption of the Recommendation Members States do respond to this challenge! As we pursue the same objectives, we shall be able to reduce the burden of injuries in EU.”

The adoption of the Recommendation is a vital step in putting injury prevention and

safety promotion higher on the policy agenda in the EU. Furthermore, it will provide adequate public legitimacy for further actions, notably, the elaboration of national action plans in the area of injury prevention and safety promotion.

To do so, the main focus of immediate EU action will be to further develop the Injury Database (IDB) on accidents and injuries with a view to achieving representative and comparable data within all Member States for the purpose of benchmarking and designing appropriate prevention policies, both at EU and national level. In addition, the Recommendation foresees a wider dissemination and implementation of prevention measures that have been proven to be successful in order to make efficient use of existing models of good practice in all Member States.

EuroSafe would like to thank all those who have been involved with or have supported the process leading up to the adoption of the Recommendation. While there is still a lot of work to be done the Recommendation should definitely help pave the way to making Europe a safer place.

The consolidated text of the Recommendation and a background note are available at:
<http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwVwContent/13councilrecommendation.htm>

► EU news

Support for new EU health strategy

There is general support for a new overarching European Health Strategy and a desire for more cooperation between the European Commission and EU Member States to further improve and protect health

in Europe, the results of a public consultation process reveal. The Commission published on 1 June a report on the consultation on the forthcoming EU Health Strategy that sums up more than 150

responses received during the process, which closed in February. The strategy, an attempt to rise to the challenges Europe will face in the coming years, will set broad objectives for health during the next decade. It will also aim to promote health across all policies and to tackle global health issues.

EU Health Commissioner Markos Kyprianou said: "There is widespread support in the health community for a strong and visionary European strategy on health. The EU is facing many new challenges which need to be tackled in a cooperative and coordinated way. This positive response recognises the EU's ability to support improvements in health across the EU and the recognition of Europe as a key player in health on the global stage."

The Commission will adopt a new Health Strategy later this year. The consultation was launched at the end of 2006 to clarify Member States' and other stakeholders' wishes and expectations relating to the strategy. The Commission's proposals to set overall objectives, and take a new approach to health in all policies and global health were welcomed. Many contributors stressed the importance of establishing an active partnership between the Commission and Member States and of open dialogue between the actors involved at all levels.

EU Health priorities

Setting objectives for core issues to protect and improve health across the EU was generally welcomed. Respondents highlighted key issues to be addressed including combating health threats, tackling inequalities including gender aspects, informing and empowering citizens, working on quality and safety in healthcare in relation to cross border issues, and addressing key lifestyle-related factors affecting health, such as nutrition and

physical activity, alcohol consumption, smoking and mental health.

Respondents also stressed the need for the further development of a European information system on health to support the strategy.

Contributors also welcomed a new approach to inter-sectoral work on health and called for enhanced coordination at EU and national levels and better coherence in policy making. The importance of health-related research and e-health was highlighted.

Global Health Issues

Respondents supported the inclusion of an international dimension in the strategy, covering broad aspects of health. They stressed the importance of interaction between the EU and other international organisations, such as WHO, in order to develop international regulatory frameworks as well as new initiatives.

Implementing the Strategy

Many contributors called for the creation of a new mechanism of structured cooperation employing the tools of the Open Method of Coordination, which is used in Lisbon strategy implementation, to promote cooperation among the Member States in the health field.

Respondents also highlighted the importance of stakeholders being involved in the Health Strategy and other policy initiatives in the health field. In this context respondents called for more clarity on the structures and objectives of current health stakeholder groups working with the Commission.

Source and more information:
<http://europa.eu/>



"EuroSafe's vision is working together to make Europe a safer place."

European Commission, businesses and NGO's create Forum to battle alcohol-related harm

More than 40 businesses and non-governmental organisations, responding to a European Commission initiative, agreed on 7 June to take action to protect European citizens from the harmful use of alcohol. EU Health Commissioner Markos Kyprianou and representatives of the businesses and NGOs signed in Brussels the Charter establishing the Alcohol and Health Forum. The Forum, scheduled to meet twice a year, is to focus especially on concrete actions to protect children and

young people and to prevent irresponsible commercial alcohol communication and sales. The move comes at a time when an estimated 200,000 Europeans die every year because of harmful alcohol use. More than one out of four deaths among young men is attributed to alcohol.

EU Health Commissioner Markos Kyprianou said: "My expectations for this Forum are high, as they need to be given the health challenge posed by alcohol-

related harm. In particular, I expect the alcoholic beverages industry to market their products responsibly. The media, advertisers, retailers, as well as owners of pubs and bars should also contribute to changing attitudes and behaviours, especially among young people. We simply cannot afford to see so many young European lives being wasted every year because of the inappropriate use of alcohol."

Platform for action

The European Alcohol and Health Forum is a common platform for action. Its members are economic operators and NGO's that are willing to devote time and resources to adopt meaningful actions to prevent alcohol-related harm. EU Member States, European Institutions, the World Health Organisation and the International Organisation of Vine and Wine participate as observers.

The Forum is to meet twice a year and to be chaired by the Commission's Directorate General for Health and Consumer Protection (DG SANCO). The Forum will establish a Science Group, which – at the request of the Forum – will provide scientific advice and guidance on matters under discussion. The Forum can also establish Task Forces. The first two have already been established and cover Marketing Communication and Youth-specific aspects of alcohol.

Members' commitments

In order to become a member of the Forum, a business or an NGO has to submit a written commitment to take action. In other words, all the members have to present a concrete action plan with objectives and information on how the results will be monitored and evaluated. Participation for the sake of participation will not be possible as members will need to report on what they have done and their achievements.

Furthermore, all action plans and commitments will be made public and all will be observed within one single monitoring framework. The results will also be made public through DG SANCO's website. This will allow the evaluation of successful initiatives, which, in turn could be examples for the other members of the Forum to follow.

Health effects of alcohol-related harm

It is estimated that harmful alcohol use kills approximately 200,000 people a year in the EU. Harmful alcohol consumption is responsible for one in four deaths among young men aged 15-29 and one in 10 deaths of women in the same age group.

According to the recently published special Eurobarometer on Alcohol, one in 10 Europeans usually drink five or more drinks in one session, which is the widely used definition of binge drinking for men. This figure was particularly high among the youngest respondents. Almost one in five young people in the 15-24 age group (19%) drink five or more alcoholic beverages in one session.

Therefore, it is no surprise that the vast majority of Europeans, according to the same Eurobarometer, would welcome measures to protect vulnerable groups of society and to reduce death by road accidents.

The Charter is available at:

http://ec.europa.eu/health/ph_determinants/life_style/alcohol/alcohol_charter_en.htm

More information: http://ec.europa.eu/health/ph_determinants/life_style/alcohol/alcohol_com_en.htm

► FOCUS on alcohol & interpersonal violence

By Professor Mark A. Bellis, Leader of the EuroSafe Task Force on Youth Violence and Karen Hughes, Manager of the Centre for Violence Prevention, Liverpool John Moores University



Each year an estimated 73,000 people die in Europe as a result of interpersonal violence. Millions more suffer physical or emotional harm from experiencing, witnessing or living in fear of violence. Preventing such violence has become a key public health priority across Europe, with much work underway to deter violence, support victims, and prevent the risk factors for involvement in violence. One of the key risk factors for both victims and perpetrators of violence is alcohol use; drinking not only increases individuals' chances of involvement in violence but also the severity of injuries sustained during violent acts. The links between alcohol and violence are complex and include:

- Alcohol having a direct effect on physical and cognitive functioning, contributing to violence through, for example, reducing self control and the ability to process information.
- Expectations and beliefs that alcohol contributes to violence leading to the use of alcohol to excuse violence.
- Problematic use of alcohol developing as a coping mechanism amongst those that have experienced or witnessed violence.
- Individuals who are dependent on alcohol neglecting care duties (e.g. towards children).

- Prenatal alcohol exposure being linked to behavioural problems in later life including delinquent behaviour and violence.

The relationship between alcohol and violence spans all types of violence, including child abuse, youth violence, intimate partner violence, sexual violence and elder abuse (see Box 1). Further, unlike many direct health problems linked to alcohol (e.g. liver disease, cancers, falls, overdose), the effects of alcohol-related violence are frequently not only experienced by the drinker but impact far more widely on families and communities, who suffer the consequences of violence committed by others. Tackling offenders and treating victims of alcohol-related violence also places huge strains on health, criminal justice and other public service resources.

Levels of alcohol use in the European region are among the highest in the world. Thus reducing hazardous and harmful alcohol use, and addressing the links between alcohol and violence, must be major considerations for violence prevention initiatives. At a policy level, measures to increase alcohol prices and regulate alcohol sales (e.g. limiting service hours) can reduce population alcohol use. More locally, strict enforcement of age of alcohol purchase legislation can reduce underage drinking while measures such as screening and brief interventions can reduce consumption in hazardous and harmful drinkers.

Box 1: Key facts and figures

- Across Europe, four in ten homicides are attributable to alcohol.
- In England and Wales, young binge drinkers are twice as likely as regular drinkers to have been involved in violence in the last year.
- A third of perpetrators and one in ten victims of intimate partner violence in Switzerland are intoxicated at the time of assault.
- Almost half of perpetrators of rape in Spain have used alcohol prior to the attack.
- In Germany, a third of perpetrators of fatal child abuse were under the influence of alcohol when committing the abuse.
- Alcohol use is the most significant risk factor for perpetration of elder abuse by carers in the UK.
- In Iceland, over a fifth of female survivors of intimate partner violence report using alcohol as a coping mechanism.

Specific to alcohol-related violence, a wide range of measures can be implemented in and around drinking environments to reduce the potential for violence to occur. These include: improving management and comfort in licensed premises; providing training for managers and bar staff; increasing the availability and safety of late night transport; improving street lighting; and targeting policing and other security in high-risk areas. Importantly many such measures will help reduce not only violence, but also other injuries such as road traffic crashes and falls.

Interventions to reduce alcohol use and tackle alcohol-related violence are an important part of violence prevention but represent only one aspect. Broader policies and strategies to prevent violence must begin with early interventions to support families in the pre- and post-natal periods. Such support can reduce the risks of children being maltreated by parents and later becoming involved in youth or even intimate partner violence. Equally however, with experience of violence in childhood being a risk factor for alcohol and drug misuse, such early life interventions can also impact on substance use later in life.

Current priority issues

Alcohol misuse and violence are among the key public health problems in Europe today. Critically, their relationship is circular, with both affecting and exacerbating each other. As risky drinking behaviours increasingly become embedded into European youth culture, policymakers and public health professionals face a growing challenge in tackling such drinking and reducing alcohol-related violence. The evidence base for preventing violence and tackling risky drinking is also growing. However, as the world's largest alcohol consumers, European countries also rely on the employment, economies and lucrative tax revenues that the alcohol industry underpins. The challenge for Europe is how to implement effective evidence based measures to reduce the consumption and often violent impacts of alcohol within acceptable economic consequences.

The way forward

Preventing violence, including that relating to alcohol, requires interventions with short, medium and, often neglected, longer-term results. For a thriving 24 hour Europe, a safer nightlife must be a priority with well designed and managed town and city centres. Interventions should improve nightlife safety without displacing alcohol-related violence into home or other settings. However, while nightlife violence is often prominent in the media, alcohol is already a major factor in intimate partner violence, sexual violence, and child and elder abuse. Despite relatively little research in such areas, greater collaboration between support, criminal justice and alcohol treatment services will help to both better identify the scale of such problems and explore potential solutions.

In the longer term however, interventions in early life supporting parents and children offer some of the most effective mechanisms for breaking the cycles which see those abused as children becoming abusers in later life with alcohol misuse frequently a feature of the perpetrators' and victims' behaviour. The evidence for such interventions is compelling and has been catalogued, evaluated and prioritised by the World Health Organization. Eurosafe must build on this work by developing networks for sharing information on the extent of, and effective prevention of, violence. As alcohol sales flourish across Europe, Eurosafe is well placed to expose this major hidden cost of alcohol consumption, all too often the price of which is paid not by the consumers but by an innocent focus of their aggression.

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Global Campaign for
Violence Prevention

► INTERVIEW with Alex Butchart:

Alex Butchart co-ordinates the Prevention of Violence Team in the Department of Injuries and Violence Prevention at WHO Headquarters in Geneva. The Team's main task is to implement the recommendations of the World report on violence and health released in 2002. This involves preparing technical guidelines, policy papers and research to support applied prevention programmes, working with countries to develop national plans of action and prevention programmes, and advocacy for increased investment in violence prevention.

In this interview, Alex answers questions on the Global Campaign for Violence Prevention that was launched in October 2002. The Campaign aims to raise awareness about the problem of violence, highlight the role that public health can play in addressing its causes and consequences, and encourage action at every level of society. On 17-19 July 2007, the Third Milestones in a Global Campaign for Violence Prevention Meeting will take place in Scotland, UK.

The upcoming 'Third Milestones' meeting in Scotland marks five years of WHO campaigning on the violence issue. What has been achieved in these years and what barriers still have to be overcome?

Much has been achieved by way of establishing an awareness that violence is preventable; consolidating and disseminating normative guidance on how to prevent violence; carving a niche within government health ministries for focal persons to promote violence prevention, and taking stock at national and regional levels of the violence and health problem and of responses to it. While in 2002 only a handful of health ministers could say why violence should be a public health priority, there have since been two World Health Assembly resolutions calling on countries to invest in violence prevention, and by 2006 three out of six WHO regional committees (Africa, the Americas and Europe) had adopted similar resolutions; there are over 100 officially appointed health ministry focal persons for the prevention of violence; over 50 countries have had national launches of the World report on violence and health, and over 25 countries have developed reports and/or plans of action on violence and health. Building upon the World report on violence and health and reinforcing its recommendations, special reports on violence against children and violence against women have been received by the UN General Assembly and have resulted in resolutions calling for

greater investment in multi-sectoral efforts to address these forms of violence.

Concrete examples of primary prevention programmes based upon WHO violence prevention recommendations include: a pilot programme being developed in Brazil to reduce child maltreatment by providing parenting training, social support and improved access to health and welfare services among teenage mothers; a Jamaican "learning for life programme" to provide disadvantaged, out-of-school adolescents with job training and employment; the development in Mozambique of a national policy for violence prevention and a surveillance system to monitor violence- and injury-related deaths and hospital emergency room presentations; and, in the Former Yugoslav Republic of Macedonia, establishment of a National Commission for the Prevention of Violence. A joint UNDP-WHO Armed Violence Prevention Programme has supported process evaluations of prevention programmes in Brazil and El Salvador. Capacity development through implementation of the WHO TEACH-VIP curriculum for training in the prevention of violence and injuries has been undertaken in dozens of countries and through several regional "training of trainers" workshops.

Through activities such as these conducted in collaboration with WHO, plus many more independently initiated projects, violence prevention has reached a turning point. Advocacy, normative guidance and the planting of programme seeds in countries must now be matched with scaled-up country-level implementation accompanied by a concerted effort to measure effectiveness using the outcomes that really matter - such as rates for violence-related deaths and non-fatal injuries; for non-injury health consequences (e.g. alcohol and substance abuse; unsafe sexual behaviour, mental health problems), and for perpetration. Recently published outcome evaluation studies from low- and high-income settings using such measures have shown remarkable reductions in various forms of violence - including youth violence, intimate partner violence and child maltreatment - because of carefully designed and properly implemented prevention strategies. If in the next five years we can get more such outcome evaluation studies from low-, middle-, and high-income countries, then arguments for the preventability of violence will be even more compelling and violence prevention should be well on its



way to being integrated into the mainstream of public health and development assistance.

The 'Third Milestones' meeting is being held in the UK with support from Scottish Executive directorates representing criminal justice and health. How did you manage to bridge the different worlds of criminal justice and public health?

When it comes to interpersonal violence, in some countries these worlds aren't that different any more. Increasingly, criminologists and criminal justice policy makers and practitioners are recognising the value of data-driven, evidence-based approaches that address the root causes of violence in the same way that public health strategies tackle underlying causes at the levels of the individual, family, community and society. In Scotland, the police and criminal justice sectors have been quick to see these synergies and to take the lead in developing an inter-sectoral violence prevention policy and plan built around three core ministries - health, education and justice: and this is no longer an isolated case.

Violence takes many forms and shapes in today's society. What are the major issues in the European region and in which areas can the public health approach make a real difference in terms of reducing the risk of injuries due to violence?

The most visible violence issue in Europe is the steep gradient from low to high rates of homicide and suicide as one moves from the high-income Western European countries (with some of the world's lowest homicide rates), to the middle- and low-income Central and Eastern European (CEE) countries (with some of the world's highest suicide and homicide rates). Bringing the CEE rates down to the levels of Western Europe would save tens of thousands of lives, and by increasing personal security in CEE countries would contribute to enhancing their overall social and economic development.

The least visible violence issue in Europe is shared by all the region's countries. This is the burden of non-injury health consequences that arise from child maltreatment, intimate partner violence and elder abuse. These include depression, suicide, and panic disorders; alcohol, drug and tobacco abuse, eating disorders, and high-risk sexual behaviour, and are spread throughout a person's lifetime. These concealed life-long consequences mean that governments everywhere are already spending a substantial portion of their health budgets treating the consequences of such violence, resources that could be far more effectively spent on primary prevention.

The biggest challenge for the whole of Europe is for more countries to understand the value of primary prevention and to invest in large-scale violence prevention programmes. Given the many consequences of violence, these programmes will also serve as disease prevention and health promotion strategies. In North America, Australia and New Zealand, violence prevention is already quite well entrenched. By comparison, the dominant response to violence in most European countries remains a reactive one, focused on working with victims and offenders after a violent incident has occurred. The health sector can make a valuable contribution to strengthening prevention capacity, particularly by highlighting and being engaged in effective preventive measures. For instance, alcohol abuse is a major risk factor for violence, unintentional injuries and a large number of non-communicable diseases, and substantial public health gains could be expected by strategies to reduce hazardous and harmful drinking.

Prevention and how can national public health institutions contribute to the campaign? What are the priorities for the next five years of the Global Campaign for Violence

Priorities for the next five years are to encourage the scaling up by national and local governments and non-government partners of investment in policies, systems and programmes that will contribute to the primary prevention of violence. Coupled with this we'd like to see national public health institutions getting more strongly behind large-scale outcome evaluation studies, and ensuring that violence and injury surveillance systems are in place to monitor the response of violence to prevention efforts, and broader social and economic changes. We would also like to see the major OECD donor countries paying more attention to violence within their international development agreements, and supporting violence prevention within developing countries where over 90% of all homicides occur and the burden of non-fatal violence is many times greater than in high-income countries. National public health institutions can play a huge role in this simply by turning more of their attention to the problem of violence and applying to it exactly the same public health principals and techniques that have so successfully been applied to the understanding and prevention of other public health threats.

More information: butcharta@who.int

► Child safety

Ministerial report back for the Children's Environment and Health Action Plan for Europe (CEHAPE)



June 13 to 15, 2007, was the interim report back for the 53 Member States of the WHO Euro region since the signing of the declaration and commitment to the Children's Environment and Health Action Plan for Europe (CEHAPE) some 2 years ago in Budapest.

During the meeting in Vienna, Austria, it was exciting to hear a number of Member States reported on injury action and specifically shared their country action by detailing their participation in the Child Safety Action Plan (CSAP) project of the European Child Safety Alliance. As well in the opening plenary by the Austrian Minister of Health, the Austrian CSAP was given as a successful country example. Multi level discussions and partnerships have been occurring in several Member States and it was positive to hear Alliance Members in Austria, Hungary and Portugal preparing and/or presenting Member State report backs.

An NGO presentation was also part of the plenary Inter-ministerial report back in which the Alliance presented the current challenges and way forward for child injury prevention in the Europe region. As part of this Inter-ministerial report back, CEHAPE awards were promoted and presented. Over 100 applicants from more than 30 countries submitted a prevention strategy related to children's environment and health. Two injury initiatives were award winners:

Safe Roads to School in Faro by the Portuguese Association for Child Safety Promotion, and Pediatric Prevention Counseling by Grosse schützen Kleine. Descriptions and photos of these award winners are also available on the Alliance website.

The next inter-ministerial report back will be held in Rome, Italy in 2009 where further



From left to right: Joanne Vincenten, Director of the European Child Safety Alliance, Dr. Elsa Rocha, Portuguese Association for Child Safety Promotion and Génon Jensen, Director Health and Environment Alliance (HEAL)



From left to right: Joanne Vincenten, Director of the European Child Safety Alliance, Gudula Brandmayr, Grosse schützen Kleine, and Génon Jensen, Director of the Health and Environment Alliance (HEAL)

progress on the 4 regional priority goals which include action on child injury prevention will be highlighted.

For more information on the presentation and awards mentioned in this article please go to: <http://www.childsafetyeurope.org>

Children and violence

In coordination with the European Child Safety Alliance spring meeting a child and violence seminar was hosted by Safe Kids Austria on June 12, 2007. The objectives of this half day seminar were to:

- Provide a greater understanding of the topic "children and violence" for Alliance country members;
- Determine who is doing what related to children and violence in the European Region and in Member States and how that work relates to Alliance country members' current activities in children's unintentional injury;
- Determine what action or linking the Alliance and its members should undertake to address children and violence related to its recently launched home safety campaign.

The seminar was opened by Dr. Katharina Purtscher, LSF Hospital Graz who addressed the scope of the issue and its relationship to child development followed by Dr. Dinesh Sethi, of WHO-Europe who described the size of the problem. Models of good practice to address children and violence in Europe were then shared by Dr. Erwin van Kerschaver of Kind and Gezin (Child and Family) followed by the results of an environmental scan of children and violence: actions and actors in Europe and Member States by Ms. Klara Johansson, Karolinska Institute. An open discussion by all participants followed with the conclusion to prepare a statement on the position of intentional related injuries in the home environment to be included with campaign materials and posted on the website.

Source and more information:
<http://www.childsafetyeurope.org>

RoSPA international conference to promote play in the great outdoors

More playgrounds should take their inspiration from the natural environment, was the message at the International Play Safety Conference hosted by the Royal Society for the Prevention of Accidents on June 14.

The aim of the conference was to help play providers think beyond fixed equipment, such as metal climbing frames and seesaws, and to look for ways of incorporating more natural elements into the spaces they oversee.

Delegates heard how stimulating, landscaped play areas set on different levels with a greater use of wood and the inclusion of plants, trees and soil, can be created in both urban and rural areas.

David Yearley, Head of Play Safety at RoSPA, said: "Children have an affinity with the natural environment and can learn a lot about the world through playing and interacting with it.

"By looking at ways of incorporating natural elements into equipped play spaces, we can ensure that even children living in urban areas have the opportunity to benefit from this experience.

"Such playgrounds, which should be as safe as necessary, rather than as safe as possible, are not only great fun, but also enable children to encounter the materials and natural features they are likely to experience throughout their lives. Children are therefore able to learn about potential risks and equip themselves with the skills necessary to deal with them."

The conference, held at Holywell Park, Loughborough University, also included a workshop on the debate surrounding the provision of facilities for equipment such as mini-motorbikes, skateboards, inline skates and wheeled trainers.

Delegates attending the conference included those with responsibility for playgrounds, parks and open spaces, as well as indoor play operators, holiday park operators and environmental health officers.

Source and more information:
<http://www.rospace.com/play/>

Commission meeting of Expert Group on Toy Safety

At the March meeting of the European Commission's Expert Group on Toy Safety, participants were informed that all parts of the revision of the Toy Safety Directive have now been settled with the exception of the chemicals part. An impact assessment for the proposed changes to the Directive, as well as a separate assessment for the chemicals part will be carried out shortly, and a public consultation will also be launched in the near future. The idea would be for the Commission to adopt the proposal for a revised Directive in November 2007.

A presentation of the study's results on certain chemicals used in toys was given, and the Commission will consider reconvening the

chemicals group. A presentation was also given by CEREPRI (Centre for Research and Prevention of Injuries) on behalf of the ANEC Child Safety Working Group on the risk of toys in food. CEREPRI asked the Commission to put requirements in the Toy Directive in order to cover these risks. Although ANEC and several Member States supported this, the Commission was still not convinced that the toy-food combination presents a risk. Participants in favour of requirements were asked to submit proposals.

Source and more information:

<http://www.anec.org>

► Consumer safety

The European Commission workshop on "Economic Operators' Obligation to Notify Dangerous Products"



On 1 December 2006 the European Commission held a workshop which focussed on the notification obligation imposed by the General Product Safety Directive ("GPSD") in relation to dangerous consumer products. It addressed technical and procedural aspects of notification and practical tips to assist businesses.

Key features of the notification obligation and the business application notification programme

The Commission reiterated its view that the GPSD's objectives are achieved by co-operation between notifying producers and distributors and the national authorities of their Member State.

Currently, hard copy notification forms are sent to national authorities in each affected Member State, which can lead to complications in cross-jurisdictional recalls and inevitably adds to the time and cost involved.

In recognition of this, the Commission has developed a new electronic system - the "Business Application" - which should be operational in the next few months. Its key features are:

- one form will be used regardless of the Member State
- the form will be available in five key languages
- the form will be accessible via the internet

- the notification process will be instantaneous and
- all notifications will be stored centrally at the Commission.

The new procedure is not without potential shortcomings, failing to recognise that direct communication with the authorities enables the notifier to establish a valuable line of communication. It also allows only very limited scope for notifiers to insert detail about the matters giving rise to the notification and the level of risk posed by the product.

The comments made by industry delegates in relation to these matters suggested that large manufacturers with reputations to protect may be reluctant to use the new system.

Exchange of information about dangerous products via Rapex

RAPEX, used by Member States to inform the Commission of measures taken to address risks posed by dangerous products in their territory, where those risks may affect other jurisdictions, potentially has considerable consequences for business, but, as the Commission emphasised, not every notification will give rise to a RAPEX alert. The risk of such an alert may be managed to a certain extent by a carefully prepared notification strategy.

RAPEX alerts provide an interesting snapshot. Statistics for the period 1 January to 30 September 2006 show that toys were the most widely notified product category (22%)

and that, generally, the majority of products originated in China (328 products).

Practical aspects of dealing with the notification obligation and Member State experience

Rod Freeman, a partner at Lovells and Editorial team member of the European Product Liability Review, provided tips to enable businesses to deal effectively with a notification process, emphasising that, rather than being a mechanical process, a notification is an exercise in communication and control, with the key objective from the notifier's perspective being the establishment of a good relationship and a meaningful dialogue with the authorities.

Five tips were offered:

- **Knowing the product and formulating the plan:** any notification must be preceded by a careful risk assessment involving a thorough investigation. A detailed corrective action plan should be compiled and given to the authorities.
- **The need for a global view and co-ordination:** Within Europe, simultaneous notification in substantially the same form should be made in all member states in which the product has been distributed. The same considerations apply if action is required in the US, in order to avoid the risk of authorities in one jurisdiction hearing about potential safety issues before they have been formally notified.
- **Communicating with the authorities:** to minimise the risk of misunderstanding or imposition of additional corrective measures, it is important to plan communications carefully. A single point of contact within the notifying company should be nominated and the information pro-

vided should demonstrate a professional and prudent approach.

- **Confidentiality:** under the GPSD there is a presumption that information will be available to the public unless it is covered by "professional secrecy" although it may be possible to agree that certain information shall be kept confidential under certain circumstances.
- **Consistency of message:** in the interests of avoiding confusion or contradiction, consistent information about the product and corrective action must be provided, and in a consistent manner.

A speaker from the Austrian consumer protection authority confirmed that in his experience the three most common problems relate to a lack of knowledge and preparation, insufficient information and a lack of co-ordination in multi-jurisdictional notifications.

Comment

With product recalls on the increase, the workshop contained valuable messages, emphasising the importance of adequate risk assessment and management strategies being teamed with clear and careful communication. Such communication can make all the difference between a successful notification and one which has long term negative effects on the business in question, something which should be borne in mind by all companies considering GPSD notifications and recalls.

Source and more information: This is a summarised version of an article published in Lovell's European Product Liability Review, Issue 26, March 2007, provided by the author: Anita Birkinshaw (anita.birkinshaw@lovells.com)

Council of Ministers adopts EU Consumer Policy Strategy

The EU Competitiveness Council has adopted the Consumer Policy Strategy 2007-2013. This measure recognises the importance of the role of consumer policy in shaping the Internal Market.

The Resolution adopted by the Council will help to streamline and integrate policies and benefit consumers.

By making the markets more efficient via consumer policy measures, the cascading effect is to boost growth and employment.

The Commission will implement this Strategy along three objectives: empowering consumers, enhancing their welfare and protecting them effectively.

The Resolution was formally adopted at the EPSCO (Employment, Social Policy, Health and Consumer Affairs) Council of 30-31 May.

Source and more information: http://ec.europa.eu/consumers/overview/cons_policy/index_en.htm

The Commission supports joint surveillance and enforcement actions related to the application of Directive 2001/95/EC on general product safety (the GPSD)

Currently, there are 3 joint surveillance and enforcement projects being supported by the Commission in the area of non-food consumer product safety. The projects involve administrative cooperation between the authorities or other designated bodies of several Member States and EFTA/EEA countries, in particular on product testing, risk assessment, market monitoring, and exchange of expertise and best practices related to market surveillance. The projects are:

SUSYSAFE

SUSYSAFE stands for Surveillance System on Suffocation Injuries due to Foreign Bodies in European children. Suffocation due to foreign bodies is a leading cause of death in children aged 0-3 and is also common in older ages, up to 14 years. The aim of the SUSYSAFE project is to establish a surveillance registry for injuries due to non-food foreign bodies' ingestion, to collect as many scientific data as possible and to serve as a basis for a knowledge-based consumer protection activity in the European market.

<http://www.susysafe.org/>

EMARS

The objective of the EMARS project is the enhancement of market surveillance through best practice. EMARS is being undertaken by Prosafe, the Product Safety Enforcement

Forum of Europe. Between 2006 and the end of 2008, market surveillance officials from across Europe will be working together to identify best practice for improving the safety of non-food consumer products. The EMARS project aims to produce a number of deliverables to help enhance market surveillance in Europe, such as a knowledge base, a rapid advice system, a best practice handbook, a risk assessment handbook and a strategy document on the future of market surveillance in the EU.

<http://www.emars.eu/>

Cord Extension Sets

The Administrative Cooperation Working Group (ADCO) under the Low Voltage Directive (LVD) is undertaking a project regarding the safety of so-called multiple outlet cord extension sets. The main objective of the project is to improve the safety of these products, which are used in all households and are often found to be unsafe. Secondly, the project aims to change cross-border market surveillance, from an often ad-hoc activity to an integral part of the daily work of market surveillance officers.

[http://forum.europa.eu.int/Members/irc/enterprise/esg/library?!=/surveillance_projects/2007_extension_cord\(restricted_access\)](http://forum.europa.eu.int/Members/irc/enterprise/esg/library?!=/surveillance_projects/2007_extension_cord(restricted_access))

Visit EuroSafe's website at
www.EuroSafe.eu.com

DG SANCO publishes 2006 RAPEX Report on dangerous consumer products

RAPEX is the EU rapid alert system for all dangerous consumer products, with the exception of food, pharmaceutical and medical devices. It allows for the rapid exchange of information, between Member States and the Commission, on measures taken to prevent (or restrict) the marketing (or use) of products posing a serious risk to the health and safety of consumers. Measures ordered by national authorities and measures taken voluntarily by producers and distributors are covered by RAPEX. The Commission publishes a weekly overview of the dangerous products reported by national authorities (RAPEX notifications) which gives information on the product, the possible danger and the measures that were taken by the reporting country.

The Annual (RAPEX) Report on dangerous consumer products, published on 19 April 2007 by the European Commission, shows that toys replaced electrical appliances as the product category most often notified. China

was indicated as the country of origin in almost half of cases notified (440 notifications, 48%). In total, restrictive measures concerning 924 dangerous products were reported through RAPEX last year, compared with 701 in 2005 - representing a 32% increase.

"The constant increase in the number of measures notified is a good sign: it shows that vigilance across Europe is getting better and better", said European Commissioner for Consumer Protection, Meglena Kuneva. The Commission is calling for enhanced participation from all EU Member States, joint efforts with and between national market surveillance and customs authorities, and co-operation with third countries to further increase the effectiveness of the RAPEX system.

Source: <http://www.anec.org>

More information: http://ec.europa.eu/consumers/dyna/rapex/rapex_archives_en.cfm

► Injury Data

The European Injury Database after “IDB-1”: Status significantly improved



The “IDB-1” (Injury Database) project of the 2003 Public Health Programme, completed in March 2007, provided central coordination and support to the national Home and Leisure Accident data collections in the EU for the first time. Under the Injury Prevention Programme, 1999-2002, the data collections were individually contracted and co-financed by DG Sanco. The challenge for “IDB-1” and the whole IDB network was to operate the Injury Database with less EU money per country but with increased demands on the consumer safety and public health relevance of the system. Owing to the great commitment of all project partners the following progress has been made during the course of the project:

- The number of regular IDB reporting countries has been increased from six in 2004 to twelve in 2006: Austria, Denmark, France, Netherlands, Portugal, Sweden; Cyprus, Ireland, Italy, Latvia, Malta, United Kingdom / Wales;
- From 2007 onwards the scope of IDB data collection has been extended from “Home and Leisure Accidents” to “All Injuries” in Austria, Netherlands, Sweden, Cyprus, Ireland, Latvia, Malta, and United Kingdom/ Wales. In addition, the following countries have provided “All Injury” IDB data from pilot implementations: Belgium, Czech

Republic, Estonia, Germany, Poland, Slovenia, and Slovakia.

- Public Access for aggregated IDB data has been established in order to provide unrestricted dissemination and use of the unique IDB information.

While the status of the Injury Database has been improved significantly during “IDB-1” there is still a lot of work to be done. This is now being carried out by “IDB-2” which is a part of the current EuroSafe project, “SafeStrat”. The main aims of the “IDB-2” project are to support the IDB pilot countries in a full “regular” IDB implementation and to get new IDB countries on board.

The incentives and benefits of joining the IDB are clear: detailed and comparable injury data across all sectors of life - work, school, traffic, home and leisure, and “violence” (see Figure 1). This is a prerequisite for the development and evaluation of injury prevention strategies as recommended by the recent Council Recommendation on Injury Prevention and Safety Promotion (see article on page 1).

All “IDB-1” reports and data will be made available at <https://webgate.cec.eu.int/idb> as soon as they have been approved by DG Sanco (expected in July 2007).

Source: Robert Bauer, robert.bauer@kfv.at

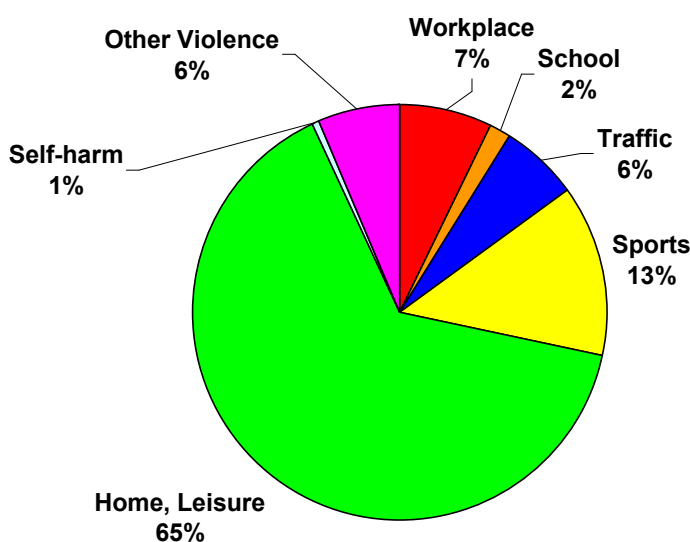


Figure 1: IDB “All Injury” data by injury prevention sector

The “All Injury” IDB will provide detailed and comparable injury data across all sectors of human life: work, school, traffic, home and leisure, and “violence” - a prerequisite for the development and evaluation of injury prevention strategies. Source: IDB pilot data 2005 and 2006 from Belgium, Czech Republic, Estonia, Germany, Latvia, Malta and Poland (34.000 cases in total; preliminary results).

► Adolescents & risk taking



Youth violence and alcohol

In the WHO European Region young people aged 18–24 are more likely than other age-groups to engage in heavy episodic drinking. Use of alcohol triggers criminal violence. However, the relationship between alcohol and violent behaviour is complex and it is moderated by various factors in the individual and the environment. It is more common for young adults than for other people to have been drinking prior to a non-fatal violent incident, regardless of whether they are the perpetrator or victim of violence.

Alcohol drinking cultures vary in the European Region; the drinking pattern is very different between northern and southern countries. High rates of explosive drinking are found in countries like Finland, Sweden, United Kingdom and the Russian Federation while in Southern European countries drinking is a part of everyday family life. While the prevalence of alcohol-related violence varies between countries, for example, 1,2 % in Italy to 7,5 % in UK, on average 3,6 % of males report having been involved in violence after drinking alcohol in Finland, France, Germany, Italy, Sweden and UK.

Young people are more likely to get involved in alcohol-related violence than other populations. For example, in Estonia 80 % of adolescents' violent crimes are related to alcohol use. In England and Wales young males aged 18–24 who drink large quantities at a time are more than twice as likely to commit violent crimes compared to non-binge drinkers.

Risk factors

According to WHO's World report of Violence individual risk factors for violence include being male, delivery complications at birth, personality and behaviour disorders, low intelligence, impulsiveness and alcohol use. Among relationship factors are poor parental supervision, harsh parental physical punishment, parental conflict, large number of children in the family, young age of the mother, poor family cohesion, single parent household, low socio-economic status of family and having delinquent friends. Structural factors include presence of gangs, guns and drugs, availability of alcohol, poor social integration, rapid demographic change in youth population, modernisation and

urbanisation, income inequality, weak governance and a culture that is supportive of violence.

Low educational expectations and having trouble at school seem to increase the likelihood of getting involving in alcohol-related violence. Moreover, hostility and anger, which facilitate aggression, have been found to increase the likelihood of involvement in alcohol-related violence regardless of sex. Home and pubs and bars are the two most common social contexts of alcohol related violence.

Having alcohol drinking peers increases adolescents' risk of involvement in alcohol-related violence. In a study of 16–17-year-olds it was found that injuries under the influence of alcohol were three times more likely in adolescents with drinking peers. As stated by a study conducted in Norway having regular drinking friends and having parents who are often intoxicated is associated to adolescents' violent behaviour.

Adolescents' level of alcohol consumption is strongly related to their risk of violence and those who start to drink at an early age drink frequently and are prone to drink large quantities. Adolescents who engage in peer drinking or problem drinking, i.e. drinking until drunk or drinking which results in problems with family, school or friends are more likely to be involved in physical violence or be victimised by it.

Variations in drinking patterns and violent behaviour can be tracked down to involvement in other problem behaviours among adolescents. Frequency in law violations and use of drugs is associated with having similarly deviant peers who support and reinforce such behaviours among adolescents. Drunkenness has more effect on boys' than on girls' violent behaviour. Furthermore, boys who have engaged in violent behaviour are more inclined to repeat such behaviour than is the case with girls. Finally, it has been shown that alcohol affects the youngest age group more which is probably due to inexperience of controlling the adverse effects of alcohol.

Source and more information: Meri Paavola meri.paavola@ktl.fi and Heli Kumpula.



► Safety for seniors

Networking to improve elderly safety

1st EUNESE conference puts elderly safety in the picture in Europe

Seventy-five professionals working in elderly safety attended the first conference of the European Network for Safety among Elderly (EUNESE) held on 14-15 May in Brussels. The issue of how to improve the safety of elderly across Europe was on top of the agenda.

In plenary sessions participants were informed about how to strengthen the policy response to the burden of injuries among elderly. Facts and figures of injuries among elderly and some controversial issues such as restraint measures in nursing homes were also discussed.

In workshops participants were given practical tools on how to improve advocacy on elderly safety, building a national network and how to implement interventions. In addition to the above mentioned subjects networking was one of the main goals of the conference. Participants had the ability to present their own work on research, policies and implementation. For example, information was presented on the National Falls

awareness day in the UK, attitudes of elderly people towards fall prevention, building a network on elderly safety in Hungary, and the implementation of a practice guideline for fall prevention in Belgium.

To promote the subject of elderly safety as much as possible a press conference was included in the programme which resulted in articles in national and European press. This media attention is critical in communicating the big burden of injuries among elderly on national and European health care systems. The next step is to build on the momentum of the conference and get the subject of elderly safety on the agenda of national governments. EUNESE would like to encourage all those concerned to actively work towards this goal.

If you are interested in the abstracts and report of the first EUNESE conference or if you want more information about interventions to improve elderly safety go to <http://www.eunese.org>



Making domestic appliances safer for older people

The results of the 2006 research project to review Parts 2 of EN 60335 standard on the safety of household appliances with respect to the safety of children and older people and people with disabilities were recently presented at the 1st EUNESE conference on 15 May 2007.

ANEC presented its successful work on using standardisation to ensure domestic appliances that are safer for older people, by revising the relevant EN 60335 standards. ANEC convinced standardisation bodies and the European Commission that standards need to cover the safety needs of vulnerable consumers. As a result, CENELEC established a working group to deal with this issue

and the Commission has issued a standardisation mandate to support this work. Conference participants showed a lot of interest in ANEC's project.

On 14 May 2007, ANEC also attended two workshops dealing with advocacy on safety of elderly and implementation of interventions. During the latter, ANEC suggested that in addition to influencing the individual behaviour of older people in order to avoid accidents, better design of products and built environments could also contribute to increasing safety.

Source and more information: <http://www.anec.org>

► Violence prevention

WHO update on Violence Prevention – addressing alcohol as an underlying factor in the WHO European Region



As mentioned in the FOCUS article violence is a cause of approximately 73.000 deaths in Europe each year, and it represents the third leading cause of death for young people aged 15-29 years in Low and Medium Income European countries. To identify and address underlying factors such as alcohol is of primary importance to achieve a full benefit of prevention and trauma care strategies. Harmful alcohol consumption is one of the other leading risk factors for both disability and preventable death and as such is responsible for about 10 per cent of disease burden in Europe. Alcohol is also a major precipitating factor both in the case of the perpetrator and the victim – it increases the risk of violence and complicates the management of trauma care. A majority of Europeans (95%) believe that alcohol is the major factor in domestic violence and violence against children, and it is present in 40% of violence-related deaths.

In the WHO European Region the resolution EUR/RC55/R9 'Prevention of injuries' emphasises the public health approach to violence and injury prevention. Forty-nine Member States have nominated a focal person for violence prevention, and six have produced national reports on violence and health - Belgium, France, Norway, Russian Federation, The Former Yugoslav Republic of Macedonia, United Kingdom. Several other countries are developing or updating national policies and programmes. The WHO Framework for alcohol policy in Europe was adopted in 2005 and it forms an important basis for development of national policies. In some countries successful national alcohol strategies have been introduced and methods are being developed to reduce alcohol-related harm. The need for urgent action is specially underlined by the increasing consumption and problems in northern and eastern Europe, and the decreasing age of the debuting alcohol consumers.

Developing national plans for violence and injury prevention creates a framework for effective action and is a central priority in country work in a number of countries. Recognising gaps in knowledge, prioritising research and strengthening national capacity to respond to the burden and risks of violence

and alcohol abuse are necessary steps to reduce the role of violence and injuries as a major threat to public health.

Some of the current developments in the WHO European Region include:

In the **Russian Federation** a workshop is planned to support the development of a common understanding of issues related to alcohol, its relation to violence and injuries and preventive policy options among key Russian stakeholders and relevant sectors.

In **Latvia** a survey among service providers for victims of violence is being carried out in order to provide an overview of the country situation, followed by analysis and recommendations for actions. The survey is serving as a first step towards a comprehensive national report on violence and health. Latvia is also planning actions to reduce alcohol availability.

Slovenia is actively working against hazardous alcohol consumption as one of the key priorities in injury prevention.

In **Romania** violence prevention is a part of the Romanian Government Programme 2005-2008, mainly addressing domestic violence. In 2006 an integrated system for data collection of domestic violence was published and there is an active effort to provide supplementary education of violence prevention to community nurses to monitor the problem. A workshop with national stakeholders for a situational country analysis with issues as alcohol and violence, domestic violence, youth violence etc. will be arranged in 2007 (to be used as a part of a national report on violence and health.)

The **Former Yugoslavian Republic of Macedonia** is one of the six countries that has completed a national report on violence and health. A multisectoral national action plan for prevention of violence will be prepared in 2007. Activities also include the development of a protocol to be used by professionals meeting a victim of violence. The protocol will contribute to an overall view of prevalence as well as to monitoring the services provided for the victims.

Norway is implementing an Action Plan against Domestic Violence 2004-2007, a joint policy document prepared by four Ministries. The Action Plan includes issues such as improving the victim support services, increasing awareness of domestic violence and preventing it through attitude change, strengthening treatment programmes for children witnessing violence and for perpetrators. In addition, a Strategy for Early Prevention of Substance Abuse is being developed.

For more information about the work and publications of the WHO Regional Office for Europe on the prevention of unintentional injuries and violence, please refer to:

<http://www.euro.who.int/violenceinjury>

e-mail: violenceinjury@ecr.euro.who.int

► Vulnerable road users

Measuring the (un)safety of roads

The Dutch Institute for Road Safety Research (SWOV) has recently published a fact sheet on measuring the unsafety of roads. In the Netherlands about an estimated quarter of all road deaths are caused by the use of alcohol. Traditional measures to reduce the unsafety due to alcohol have increasingly less effect. A new measure would be the introduction of a compulsory 'alcolock' for those found guilty of drink-driving. What is an alcolock? An alcolock is an alcohol tester connected to a car's ignition. It functions as an ignition interlock. The blockage of the starting mechanism is only removed after the driver passes a breath test.

Until now, the most widely used and most reliable testers for alcolocks are breath testers with an electrochemical fuel cell as sensor. The Dutch police use such testers for tracing drink-drivers. There are also some cheaper alcolocks for sale in which the breath tester works according to the semi-conductor

principle.

However, the sensor in such a tester is less stable and has to be calibrated more frequently. A recent development is testers with sensors in the steering wheel that measure the amount of alcohol from perspiration in the palm of the hand. However, the reliability of this method has not yet sufficiently been proven.

This fact sheet discusses the advantages and disadvantages and presents the results of evaluation studies in other countries. The costs and benefits are also considered. SWOV concludes that the alcolock is an effective new weapon in the battle against drink-driving in Dutch traffic.

Source and more information: http://www.swov.nl/rapport/Factsheets/FS_Alcolock.pdf



Website to help drivers and riders stay in control

A new website aimed at making Great Britain's roads safer by targeting driver and rider behaviour has been launched by the Royal Society for the Prevention of Accidents (RoSPA).

The RoSPA Advanced Drivers and Riders website (<http://www.roadar.org>) not only provides information for existing advanced motorists, but includes advice for all road users on safer driving and riding techniques including a special area dedicated to young drivers. The website's motto is "Whatever the weather, whatever the conditions, know you are in control".

A recent study revealed that an error or reaction by a driver or rider, such as failing to look properly or swerving, was among the causes of 66% of all accidents on Britain's roads. An injudicious action, such as exceeding the speed limit or going too fast for the conditions, was cited for 28% of accidents, and behaviour or inexperience, including aggressive driving, was mentioned for 25% of accidents.

Kevin Clinton, Head of Road Safety at RoSPA, said: "In 2005, 3,201 lives were lost on Britain's roads. RoSPA believes a greater focus on safer driving is key to reducing this

toll. Most motorists think they are both safer and more skilful than the average road user, yet the statistics show that human error is a major cause of accidents."

Emma Middleton, Development Officer for RoSPA Advanced Drivers and Riders, said: "It is all too easy to develop poor driving or riding habits without realising. For this reason, RoSPA encourages all road users to consider some kind of refresher training.

RoSPA Advanced Drivers and Riders groups, which exist across the country, provide a

valuable opportunity for motorists to develop their skills. They help people prepare for an advanced driving test, whether it has been many years since they passed their original test or just a matter of months. We hope the new website will inspire and assist existing group members as well as others who are looking to increase their safety and enjoyment on Britain's roads."

Source: RoSPA

More information: <http://www.roadar.org>

► Work safety

A draft global plan of action for Workers' health (the 60th World Health Assembly, Geneva, 14-23 May 2007)



The supreme decision-making body of WHO, the Assembly, has discussed and adopted the WHO Global Plan of Action on Workers' Health 2008-2017, where Member States have been urged to:

1. devise national policies and plans for its implementation;
2. work towards full coverage of all workers with essential interventions and services for primary prevention of occupational and work-related diseases and injuries;
3. build institutional and human resource capacities for dealing with working populations;
4. ensure collaboration and concerted action by all national health programmes relevant to workers' health;
5. encourage incorporation of workers' health in the different non-health national and sectoral policies, and
6. encourage collaboration between developed and developing countries in implementing the plan.

The Global Action Plan recalls the WHA49.12 resolution endorsing the WHO's global strategy for occupational health linking its objectives to those of health promotion as well. The Global Action Plan considers the following fundamental points:

- Workers represent half the world's population and are the major contributors to economic and social development. Their health is determined not only by workplace hazards but also by social and

individual factors and access to health services.

- Despite the availability of effective interventions to prevent occupational hazards and to protect and promote health at the workplace, large gaps exist between and within countries with regard to the health status of workers and their exposure to occupational risks. Still only a small minority of the global workforce has access to occupational health services.
- Increasing international movement of jobs, products and technologies can help to spread innovative solutions for prevention of occupational hazards, but can also lead to a shift of that risk to less advantaged groups. The growing informal economy is often associated with hazardous working conditions and involves such vulnerable groups as children, pregnant women, older persons and migrant workers.
- The present plan of action deals with all aspects of workers' health, including primary prevention of occupational hazards, protection and promotion of health at work, employment conditions, and a better response from health systems to workers' health. It is underpinned by certain common principles. All workers should be able to enjoy the highest attainable standard of physical and mental health and favourable working conditions. The workplace should not be detrimental to health and well-being. Primary prevention of occupational health hazards should be given priority. All components of health systems should be involved in an integrated response to the specific health

needs of working populations. The workplace can also serve as a setting for delivery of other essential public-health interventions, and for health promotion. Activities related to workers' health should be planned, implemented and evaluated with a view to reducing inequalities in workers' health within and between countries. Workers and employers and their representatives should also participate in such activities.

Moreover, it establishes the following main objectives:

- to devise and implement policy instruments on workers' health;
- to protect and promote health at the workplace;
- to improve the performance of and access to occupational health services; and
- to incorporate workers' health into other policies.

Furthermore, the Health Assembly has requested WHO:

- to promote the implementation of the global plan of action at international and national levels;
- to stimulate joint regional and country efforts with ILO;
- occupational health; and
- to maintain and strengthen the network of WHO collaborating centres for occupational health; and
- to report to the Health Assembly in 2013 and 2018 on progress made in implementation of the global plan of action.

Source and more information:

<http://www.who.int/mediacentre/events/2007/wha60/en/index.html>

Violence at work – A major workplace problem and concern

It is only recently that violence at work has started to receive the attention that it deserves: it bears a high cost for victims and enterprise performance alike as well as being a serious safety and health hazard. The figures speak for themselves:

- Acts of violence against public transport personnel have been rising rapidly in France, with over 2,000 attacks reported in 1998 on the staff of the Régie Autonome des Transports Parisiens (RATP);
- In Germany, 93% of the women questioned had been sexually harassed at the workplace, according to an extensive national survey conducted in 1991 by the Federal Institute of Occupational Health and Safety.
- In the United Kingdom, a survey conducted by the British Retail Consortium covering the 1994/95 financial year found that over 11,000 retail staff had been the victims of physical violence and over 350,000 had been subject to threats and verbal abuse.

The International Labour Organisation's (ILO) continuing dedication to the protection of workers and to a safe and productive working environment has contributed to the publication of the third edition of a publication on violence in the workplace, titled 'Violence at work'. As raised in the publication, experience shows that "the most effective solutions are obtained when the issue is addressed by an active partnership of all the actors concerned" including governments, trade unions and employers. Hopefully, the response at the national and international levels is taking shape. For example, the European Commission is analysing the action to be taken for the prevention of workplace violence in the European Union as part of its current programme on safety, hygiene and health at work.

Violence at work takes a very broad range of forms and behaviours

The borderline of what constitutes acceptable behaviour is often vague as cultural attitudes to what amounts to violence are very diverse as well. Therefore the definition of what violence at work is turns out to be a very complex matter; it may consist of overlapping behaviour, including non-physical or

psychological violence, or repeated actions which, by themselves may be relatively minor, but which can cumulatively come to constitute serious forms of violence such as sexual harassment, bullying or mobbing.

The Third European Survey on Working Conditions, based on 21,500 face to face interviews with workers throughout the EU indicates that:

2% (3 million) workers are subjected to physical violence from people belonging to their workplace and 4% (6 million) workers are subjected to physical violence from people outside their workplace

2% (3 million) workers are subjected to sexual harassment and 9% (13 million) workers are subjected to intimidation and bullying

Even if no occupation is immune, violence at work tends to be more of a risk in certain occupations than in others, health care being prominent among the high risk sectors. In particular, workers who perform certain types of task seem to be specially exposed to risk:

- handling money or valuables (cashiers, transport workers, bank and post office staff, shop assistants);
- providing care, advice, education and training (nurses, ambulance staff, social workers, teachers);
- carrying out inspection or enforcement duties (police and traffic wardens, ticket inspectors);
- working with mentally disturbed, drunk or potentially violent people (prison officers, bar staff, mental health workers);
- working alone (home visitors, taxi drivers, domestic repair workers).

Several factors appear to increase a workers' risk of suffering violent treatment at the workplace, and sex, age and precarious employment seem to be chief. Several surveys appear to confirm the vulnerability of younger workers to violent victimisation at the workplace. In the United Kingdom, for example, staff aged 18 to 30 working on the London Underground have a higher probability of becoming victims of assault than older staff. Women are also at particular

risk of violence, both inside and outside the workplace. Data from Sweden also shows women to be more at risk of workplace injuries caused by violence than their male colleagues. On the one hand, because women are mostly employed in the high-risk occupations (as teachers, social workers, nurses and other health-care workers, as well as in banks and shops). On the other hand, the continued segregation of women in low-paid and low status jobs also contributes to the problem. Yet, men tend to be at greater risk of physical assault, whereas women are particularly vulnerable to incidents of a sexual nature.

Differences between countries

There are also considerable differences in reporting violence at work between the various Member States. For example: 15% in Finland, 14% in UK and The Netherlands, 12% in Sweden, 11% in Belgium, but only 4% in Italy and Portugal, 5% in Spain. This leads to the suspicion that underreporting and greater awareness may be at the origin of these differences.

As awareness of the problem of violence at work increases, knowledge of what can be done about it is growing. In particular, it is recognised by many experts that a comprehensive approach has to be adopted, rather than searching for a single solution to any problem or situation. The full range of causes which generate violence should be analysed and a variety of intervention strategies adopted. Responses to workplace violence are frequently ineffective because they are limited in scope, episodic and ill-defined.

It is now more widely understood that violence at work is not an isolated, individual problem, but a structural, strategic issue rooted in wider social, economic, organisational and cultural factors. The response should therefore be directed at tackling the causes, rather than the effects of violence at work through the adoption of a preventive, systematic, participative and targeted approach.

Source: *Duncan Chappell and Vittorio di Martino, Violence at work, third edition, International Labour Office, Geneva, 2006.*

More information: <http://www.ilo.org/public/english/protection/safework/violence/index.htm>

► Cross-cutting issues

Overview of health statistics collected by EuroStat

What is Eurostat?

Eurostat's mission is to provide the European Union with a high-quality statistical information service. Eurostat is one of the Directorates-General (DGs) of the European Commission and it is situated in Luxembourg. Its task is to provide the European Union with statistics at European level that enable comparisons between countries and regions. A key role is to supply statistics to other Commission DGs and other European Institutions so they can define, implement and analyse Community policies.

Eurostat's work is carried out within the European Statistical System (ESS). The ESS comprises Eurostat and the national statistical authorities, i.e. all national providers of official statistics such as the statistical offices, but also ministries, agencies and central banks that collect official statistics in EU Member States, Iceland, Norway and Liechtenstein. Member States collect data and compile statistics for national and EU purposes. The ESS functions as a network in which Eurostat's role is to lead the way in the harmonisation of statistics in close cooperation with the national statistical authorities. The ESS also coordinates its work with international organisations such as OECD, the UN, the International Monetary Fund, and the World Bank.

The general framework of Eurostat's work is defined by the Statistical Law adopted by the Council in 1997. The main aims of the European Statistical System are given in the Statistical Programme agreed by the European Parliament and the Council every five years (currently 2003-2007 and 2008-2012 under preparation). For most of the data collections there is a specific European level legal act defining the general framework and specificities, but some data collections still rely on voluntary gentlemen's agreements. The rules within the ESS for the production of statistics are governed by the European Statistics Code of Practice.

Eurostat has seven Directorates, two horizontal ones for Resources and Statistical methods, tools and dissemination and five for specific areas of statistics:

- National and European accounts
- Economic and regional statistics

- Agriculture and environment statistics; statistical cooperation
- Social statistics and information society
- Business statistics

Eurostat statistics as well as most publications are available on-line free-of-charge at Eurostat's website:

<http://ec.europa.eu/eurostat>

Health and Safety statistics in Eurostat

The activities on health statistics are located in Directorate F – Social Statistics and Information Society. Within the Directorate, the unit F-5 Health and food safety statistics is in charge of public health statistics and health and safety at work statistics, the other activities of the unit being food safety statistics and crime statistics.

The main data collections in the field of Public Health are:

1. Causes of Death statistics, COD

Eurostat disseminates COD statistics according to a shortlist of 65 causes, based on the ICD – classification of WHO. Data are available at national and regional level for total number, crude death rates and standardised death rates, broken down by age groups and by sex.

2. Health Care statistics, CARE

Health care expenditure data collection by Eurostat started recently as a joint OECD/WHO/Eurostat activity and based on the System of Health Accounts. The non-expenditure health care data cover 'manpower' (health care staff) as well as hospital statistics.

3. Health Interview Surveys (including disability), HIS

Up to 2004, Eurostat collected data on 18 items from national Health Interview Surveys and post-harmonised the data to the extent possible. In 2007/2008 a harmonised European Health Interview Survey (EHIS) will be implemented in the ESS and will then be carried out every five years.

4. Diagnosis-specific morbidity statistics, MORB

From 2007 onwards, diagnosis-specific morbidity statistics become a new strand of

European public health statistics. The aim is to achieve a sustainable data provision on a regular basis for a selected set of diseases within the ESS to provide a general picture of diagnosis-specific morbidity at population level.

In the field of Health and Safety at Work the following statistics are collected:

5. European Statistics on Accidents at Work, ESAW

Eurostat disseminates ESAW statistics for non-fatal accidents at work with more than 3 days of absence as well as fatal accidents at work. A separate data collection is carried out for commuting accidents (accidents on the way from home to work or vice versa).

6. European Occupational Diseases Statistics, EODS

Eurostat disseminates EODS statistics for incident occupational diseases and deaths due to occupational disease. The statistics cover only the cases recognised as occupational diseases by the national authorities.

7. Ad hoc Surveys on Health and Safety at Work

To complement the administrative ESAW and EODS data, ad hoc modules on health and

safety at work outcomes are carried out. These aim to cover groups that are not comprehensively included in the administrative statistics (e.g. self-employed, the public sector), less severe accidents, and work-related diseases not recognised by the national authorities. An ad hoc module on accidents at work and work-related diseases was included in the 1999 Labour Force Survey (LFS) and is included again in the 2007 LFS.

Source: Antti Karjalainen, EuroStat (Antti.KARJALAINEN@ec.europa.eu)

More information on the above-mentioned data collections on Public health statistics can be found in:

<http://forum.europa.eu.int/Public/irc/dsis/health/library>

and on Health and safety at work statistics in:

<http://forum.europa.eu.int/Public/irc/dsis/hasaw/library>

The detailed Background Note on EuroStat's activities is available at:

http://circa.europa.eu/Public/irc/dsis/health/library?l=/statistics_information/background_2006pdf/EN_1.0_&a=d

New European Public Health Alliance (EPHA) President

At the recent EPHA Annual General Meeting, Joanne Vincenten, Director of the European Child Safety Alliance, EuroSafe, has recently been appointed President of the Executive Committee for a two-year term. Prior to this appointment Ms. Vincenten was a member of the Executive Committee for 6 years.

The European Public Health Alliance (EPHA) represents over 100 non-governmental and

other not-for-profit organisations working in support of health in Europe, thirty-five of which are pan-European or international networks. EPHA aims to promote and protect the health interests of all people living in Europe and to strengthen the dialogue between the EU institutions, citizens and NGOs in support of healthy public policies.

More information: <http://www.ephao.org>

EUPHA section on Injury Prevention and Safety Promotion

The European Public Health Association, or EUPHA in short, is an umbrella organisation for public health associations in Europe. EUPHA was founded in 1992 and is an international, multidisciplinary, scientific organisation, bringing together around 12,000 public health experts for professional exchange and collaboration throughout Europe.

EUPHA has many different thematic sections spread across the spectrum of public health including a section on Injury Prevention and Safety Promotion which was started on November 16, 2006. The aim of this section is to enhance communication in injury and violence prevention and safety promotion within the public health field across Europe. In particular, the section plans to:

1. increase awareness of injury and violence prevention and safety promotion in the public health research community,
2. increase the visibility of issues related to injury and violence prevention beyond the community of injury researchers
3. strengthen the links between researchers, policy makers and practitioners;
4. support the dissemination of research results and their implementation into practice.

How to become a member

It is not necessary to be a EUPHA member to join the section and membership is free.

To join go to the EUPHA website homepage and click on the link 'Register here for the EUPHA database'. Enter a login name, password and email. Then you will be asked for your profile details and click on the Injury Section to become a member.

It is necessary to register into the EUPHA Database to activate a membership. Once registered, the member will receive a quarterly Injury Section Update with information on activities and events within the section.

For comments or questions please contact Mathilde Sengoelge:

msengoelge@hotmail.com

► AGENDA

2007

17-19 July, Kincardine, Scotland
**Global Campaign for Violence Prevention
 Third Milestones Meeting**
 More info: + 41 22 791 4001

25-29 August, Florence, Italy
**13th International Congress of the
 European Society for Child and Adolescent
 Psychiatry "Bridging the gaps –
 Integrating perspectives in child and
 adolescent mental health"**
 More info: <http://www.escap-net.org/>

27-30 August, Glasgow, Scotland
**12th European Symposium on Suicide
 and Suicidal Behaviour**
 More info: organising@esssb12.org

28 August - 1 September, Killarney, Ireland
**XXIV World Congress International
 Association for Suicide Prevention
 "Preventing Suicide across the Life Span:
 Dreams and Realities"**
 Website: www.iasp2007.org
 Tel: + 353 94 9250858
 Fax: + 353 94 50859
 Email: info@iasp2007.org

3-5 September, Halmstad, Sweden
The Tylösand Conference
 Website: <http://www.tylosandconference.com>
 More info: info@mhf.se

10-15 September, Moscow, Russia
**World Social Security Forum 29th ISSA
 General Essembly**
 Website: <http://www.issa.int/pdf/GA2007/Announcement.pdf>

13-15 September, Barcelona, Spain
**European Conference on Mental Health,
 "Joining Forces across Europe for
 Prevention and Promotion in Mental
 Health"**
 More info: <http://www.imhpa.net/conference/>

17-21 September, Paris, France
**23rd World Road Congress
 Paris 2007: The choice for the sustainable
 development**
 Website: <http://www.paris2007-route.org>

27-29 September, in Matosinhos and Porto,
 Portugal
**The ILS World Water Safety 2007
 Conference and Exhibition**
 Email: asnasa@netcabo.pt
 More info: www.worldwatersafety.org

10 October, Helsinki, Finland
EUPHA Pre-Conference 'Impact of intentional and unintentional injuries on physical and mental health'
 More info: <http://www.eupha.org>

11-13 October, Helsinki, Finland
EUPHA Conference
 More info: <http://www.eupha.org>

15-18 October, Como, Italy
First International Forum Towards Evidence-Based Toxicology
 More info: <http://www.ebtox.org/events.htm>

2008

17-19 March, Coventry, UK
5th Warwick Healthy Housing Conference
 More info: <http://www2.warwick.ac.uk>

15-17 March, Merida, Mexico
9th World Conference on Injury Prevention and Safety Promotion. Safety 2008
 Website: <http://www.safety2008mx.info>

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.

If you are an expert in a particular field please go to the Contact Directories section of the EuroSafe website:

<http://www.eurosafe.eu.com/csl/eurosafe2006.nsf/www/VwContent/I2whoiswhoexpertdirectory-.htm>

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