World Health Organization
REGIONAL OFFICE FOR Europe

South-eastern Europe sub-regional workshop:

"Improving capacity for injury prevention through improved injury surveillance"

MEETING REPORT

Chisinau, Republic of Moldova
12–13 November 2015

Helsedirektoratet
Norwegian Directorate of Health

Abstract

National focal persons on violence and injury prevention in South-east Europe (SEE) met on 12–13 November 2015 in Chisinau, hosted by the Ministry of Health of the Republic of Moldova, to take stock of achievement in improving injury surveillance over the past four years. This was the 4th sub-regional meeting of the SEE countries on "Improving capacity for injury prevention through improved injury surveillance" organized by the WHO Regional Office for Europe and supported by the Norwegian Directorate of Health. National focal points from seven SEE countries reported how national surveillance of injuries and violence was strengthened in their countries. While quality and completeness of mortality and in-patient data has improved, the registration of non-fatal injuries particularly for out-patients remains challenging to countries. Experience from Norway, European projects and several SEE countries indicates that in countries were complete registration with ICD-10 codes up to the 4th and 5th digit in hospitals is not achievable, the use of a minimum data set should be considered. Minimum data sets can provide conclusive data for policy decisions. For informing prevention programmes, however, more in-depth data might be needed. High quality injury data provide relevant information for policy making and to advocate for political action and mobilize resources for injury prevention.

Keywords

ACCIDENT AND INJURY PREVENTION
CAPACITY BUILDING
INJURIES
INTERNATIONAL COOPERATION
PREVENTIVE MEASURES
SURVEILLANCE

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ABBREVIATIONS

ECHI	European Core Health Indicators
ED	Emergency Department
EU	European Union
EUROSAFE	European Association for Injury Prevention and Safety Promotion
ICD-10	International Classification of Disease, tenth Revision
ICPC	International Classification of Primary Care
IDB-MDS	European Injury Data Base Minimum Data Set
JAMIE	Joint Action on Monitoring Injuries in Europe
MDS	Minimum Data Set
SEE	South-east Europe
TEACH-VIP	Training, Educating and Advancing Collaboration in Health on Violence and Injury Prevention - comprehensive injury prevention and control curriculum
WHA	World Health Assembly
WHO	World Health Organization

ACKNOWLEDGEMENTS

The SEE sub-regional workshop "Improving capacity for injury prevention through improved injury surveillance" was generously supported by the Norwegian Directorate of Health and organized by the WHO Regional Office for Europe on 12–13 October 2015 in Chisinau, Republic of Moldova. WHO also wishes to thank the Ministry of Health of the Republic of Moldova for kindly hosting the meeting.

This report has been written by Dimitrinka Jordanova Peshevska, Josephine Jackisch and Dinesh Sethi, WHO Regional Office for Europe and reviewed by Johan Lund, Rupert Kisser and Trudy Wijnhoven.

INTRODUCTION

Injuries caused 555 000 deaths in the World Health Organization (WHO) European Region in 2011, posing a threat to the Region's economic and social development *(1)*. Three World Health Assembly (WHA) resolutions, WHO Regional Committee for Europe resolution EUR/RC55/R9 on the prevention of injuries in the European Region *(2)* and the Recommendation of the Council of the European Union 2007 on the prevention of injury and promotion of safety *(3)* placed violence and injury prevention on the public health agenda. All of them emphasized the importance of surveillance as an integral first step to prevention.

Member States appointed National Focal Persons for injury prevention to facilitate the exchange of relevant information and experiences across the Region, and strengthen the regional and national capacity to advocate for injury prevention, promote evidence-based preventive strategies and develop cross-sectoral partnerships. The 2010 report *Preventing injuries in Europe: from international collaboration to local implementation (4)* shows good progress in European countries towards implementation of the Regional Committee resolution EUR/RC55/R9 since creation of the European network of national focal persons in 2005. For instance, increasing numbers of countries have developed national policies, strengthened their surveillance systems, and implemented evidence-based prevention programmes. This is far from widespread and the report also highlights a need for a more systematic approach in health systems to surveillance as a corner stone to advocating for policy and programme development and evaluation.

The Norwegian Directorate of Health has supported the area of injury surveillance and prevention for the last several years. Since 2010, there has been increasing recognition of the need to focus on building capacity in injury surveillance in SEE countries in order to exchange expertise and best practices within the sub-region and from other countries in the European Region. While injury mortality data are available in all SEE countries, many countries in this sub-region do not have s injury surveillance systems for non-fatal injuries and violence. In recognition that surveillance is an essential first step in the public health approach to injury prevention, the Norwegian Directorate of Health has developed an emergency department and hospital injury surveillance system which is being routinely used to monitor injuries and to evaluate prevention efforts.

The workshop on injury surveillance organized by WHO on 12-13 November 2015 in Chisinau, Republic of Moldova was the fourth in this series of workshops. The previous workshop held in October 2014 for this group of countries presented WHO's TEACH-VIP curriculum *(5,6)*. A core module on injury surveillance can be used in national contexts in order to build health system capacity to collect, analyse and interpret injury data and support injury prevention.

The aims of the fourth sub-regional workshop were to:

- take stock of achievements and changes in injury surveillance systems over the past four years in SEE;
- exchange expertise between participants in the sub-region and identify opportunities for collaboration to address common challenges;
- discuss how injury surveillance can be mainstreamed into health professional training curricula to improve the organization of data collection in hospitals and emergency units;
- increase understanding between participants in the sub-region of the key advances being made in these areas in the European Region.

The format of the meeting was a series of key note lectures followed by group discussions. The detailed programme is attached in Annex 1. Twenty persons participated in the workshop including injury surveillance focal points from seven SEE countries (Albania, Bosnia and Herzegovina, Croatia, Montenegro, Republic of Moldova, Romania, Serbia), plus delegates from Norway, European Association for Injury Prevention and Safety Promotion (EUROSAFE) and representatives from the WHO Regional Office for Europe as presented in Annex 3.

OPENING

Participants were welcomed by Dr Gheorghe Turcanu, Deputy Minister of Health of the Republic of Moldova who drew attention to the importance of the topic of injury surveillance discussed at this meeting. The Republic of Moldova has growing and extensive experience in injury surveillance. This meeting presents an important moment to exchange experience with experts and countries in the sub-region about the quality of monitoring of injuries and to review existing systems to reflect most effective ways of recoding injuries. The Deputy Minister emphasized the importance of good statistical data as critical to mobilizing the necessary budget for effective injury prevention. Mr Jakob Linhave, Deputy Director General of the Department of Public Health, Norwegian Directorate of Health opened the meeting.

INJURY SURVEILLANCE IN EUROPE

Dr Dinesh Sethi (Programme Manager Violence and Injury Prevention, WHO Regional Office for Europe) introduced the workshop by recalling the central role of injury surveillance in the public health approach to injury prevention. Since the first sub-regional meeting in 2010 important progress has been made in compiling data on injury and violence across the WHO European Region. The collaboration between WHO and national focal persons in the European Region culminated also in the publication of key publications including the *European Facts and* the *Global status reports on road safety* (2009, 2013, 2015), *Global status report on violence prevention 2014* and the *European report on preventing child maltreatment 2013*. Despite progress in SEE countries in the production of high quality mortality data on injuries, less is known about non-fatal injuries. The past three workshops have shown that challenges remain in the routine collection of injury data from emergency departments and primary health care. Motivated and trained health care staff are needed to collect a standardised and complete set of data. The TEACH-VIP curriculum has useful training materials.

THE NORWEGIAN INJURY SURVEILLANCE SYSTEM

Dr Johan Lund (The Norwegian Directorate of Health) presented the importance of injury data registration for policy making based on experience in Norway. Recording data on injuries is of great significance for monitoring the injury burden, as well as for monitoring the effectiveness of policy actions and evidence-based preventive measures. Norway uses injury data to advocate for political action and prioritize decisions.

For the purpose of political priority setting, Norway found it important and cost-effective to collect few data that were representative, the so-called “minimum data set” (MDS). However, planning of preventive measures and understanding of the cause of injuries requires a more detailed set of data, the so-called “expanded data set”. An expanded data set does not necessarily have to be representative but allows for in-depth investigation into why injury happens, e.g. causes, mechanisms, place of occurrence and activity when injured, injury severity, potentially complemented with narrative descriptions. For all patients age, sex and address are registered and can thus be used for disaggregation.

An ideal injury surveillance system collects data with a high level of detail on injury etiology that is complete or representative of the whole country, but such systems are expensive and time consuming for most contexts. Dr Lund suggested that an alternative model could be a two-step data collection system comprising: 1) a comprehensive registration of injuries using a minimum data set with representative data; 2) a periodic in-depth study of a small number of different injury types with an expanded data set.

In the case of Norway, the complete and routine registration of chapter XX of the International Classification of Disease, tenth Revision (ICD-10) to the 4th and 5th digit for all in- and out-patients was considered challenging. The completeness of the 4th and 5th digit was very low. Therefore collecting the Norwegian MDS was found to be simpler and easier to collect than ICD-10 chapter XX, all five digits. Different injury information data sets are collected in different parts of the health system. For example, in primary care (e.g. general practitioners) the International Classification of Primary Care (ICPC) is used; for hospital patients the ICD-10 chapter XIX (injury diagnosis) is used; and for in- and sometimes also for out-patients chapter XX with 5th digits – the three first for mechanisms, 4th for place of occurrence and 5th for activity when injured – is used. Norway's MDS for injury includes simplified items on place of occurrence and on activity-while-injured.

The Norwegian MDS was implemented in all hospitals countrywide in 2009 to monitor injures for all in- and out-patients. In 2015, completeness was about 50 % whereby a great variation between hospitals was noted. At present an evaluation is taking place that will provide the Ministry of Health with recommendations for improvement. Preliminary findings suggest establishing «super-users» for each institution who are trained in data registration and in regular contact with national authorities.

Dr Lund described a proposal how the lessons learnt from Norway could be translated into an injury registration system in SEE countries. He suggested a selection of few pilot hospitals to introduce a MDS in the initial implementation phase as a first step. Then to gradually expand MDS registration to all hospitals. Thereby it would be important to motivate the pilot hospitals with human resources and training. In-depth investigations could be carried out in these pilot hospitals as well. A central unit for collecting, analysing and disseminating the data may be needed as well as continuous training, follow-up and feedback to hospital staff.

JAMIE MINIMUM DATASET: STRENGTHS, WEAKNESSES, CHALLENGES AND OPPORTUNITIES FOR IMPLEMENTATION AT COUNTRY LEVEL

Dr Rupert Kisser from EUROSAFE described the legal framework for EU statistics as per the EU regulation 1338/2008 on public health statistics *(7)*. Europe aims to set up a standardized data collection system which fulfils quality requirements such as, validity, comparability, accessibility, sustainability and impartiality, reliability, and cost-effectiveness. Within the European Core Health Indicators (ECHI) 2010, a short-list of 88 relevant and feasible indicators was proposed that encompass health status, health determinants, and health care. The injury data base minimum data set (IDB-MDS) was developed by the Joint Action on Monitoring Injuries in Europe (JAMIE) project (2010–2013). The IDB-MDS can be recorded without additional burden to Emergency Department (ED) staff and patients. For the IDB-MDS, data are collected on three broad areas: 1) medical history of patient (intent, injury mechanism, setting, activity and optional narrative); 2) diagnosis (type of injury, injured body part, further treatment) and 3) administrative data (age, sex, country of residence). Currently 22 EU countries use the IDB-MDS and four countries intent to restart implementation.

The IDB-MDS has the following strengths: it refers to a relatively small data set, data are easy to collect, data are useful for public health policy making, and it is possible to extract the data from other coding systems (such as ICD-10 XX). Furthermore, the use of a standardized minimum data set fulfils an increasing demand for comparable health statistics and fits in with E-Health development. For the implementation of a MDS countrywide, the following challenges may need to be overcome: a limited understanding by emergency department staff for the use of these data for prevention purposes, competing demands on time, the requirement of compatible IT systems,

budget cuts, data protection issues and the requirement for legislation, and lack of organizational capacities.

Dr Kisser presented a new project (BRIDGE Health (Bridging Information and Data Generation for Evidence-based Health policy and research)) that was launched in 2015 to develop a comprehensive and sustainable European health information structure that will incorporate know-how and technical tools to coordinate and harmonize research and surveillance of ECHI, population and health system monitoring. The further implementation of IDB-MDS in the EU is one of the project's work-packages. The BRIDGE Health project provides a number of interesting options for collaboration in the future.

COUNTRY PRESENTATIONS: AN UPDATE FROM 2014

Country presentations included a summary of the status of national injury surveillance systems that were based upon a template (see Annex 3). Presentations focused on changes in the last year in registration of injury mortality and their classification, hospital in-patient data and emergency department data on injuries.

Albania

The Albanian government considers injury prevention – road safety in particular – as a priority. Policy developments in recent years included new legal frameworks for emergency services and road traffic injuries. A significant nationwide development in 2015 was the implementation of an E-Health information system. Implementation of the E-Health system started this year in six of the 44 public hospitals for in-patients, and the need to build capacity of staff working on data collection was noted. Road traffic injuries, falls and sharp implements are currently the main causes of unintentional injury admission. Albania saw a 30% decrease in road traffic injuries in the last years. Sources of injury data included hospitals, emergency departments, police, Ministry of Transport, research institutes and health insurance. Injury data was available by age, gender and region but reporting was paper-based. Several attempts to introduce the ICD-10 have failed so the ICD-9 (9th Revision) is still being used. It is hoped that ICD-10 will be introduced in 2016 and that the E-Health information system will improve the availability and quality of injury information from 2016 onwards.

Bosnia and Herzegovina

There is no uniform system for collection of injury data in Bosnia and Herzegovina. In the Republika Srpska[1] the Ministry of Interior is collecting injury data on injuries and there is an annual report on the Health Status of the Population in the Republika Srpska and Demographical Statistics Bulletin. In the Federation of Bosnia and Herzegovina, the Public Health Institute is responsible for collecting public health data. Injury data are gathered from health centre's monthly activity reports, individual hospital report data sheets, and reports on occupational injuries. Injury mortality data with ICD-10 classification are available and can be disaggregated by gender, age, region and year. ICD-10 classification is also used for injury morbidity data, mostly with three digits but it is not obligatory to register all injured patients. Two clinical centres – covering approx. half of the Federation – collect good quality data on admissions electronically. Collection and reporting in primary health care centres is mostly paper-based. A need for capacity building in data collection and analysis was expressed. Injury data, with the exception of road safety data, are not regularly shared across sectors but available upon request.

[1] There was no representative from the Republika Srpska at the meeting.

Croatia

Injuries are the third cause of death in 2014 in Croatia and the leading cause of death in children and young people, with falls, suicides and traffic crashes leading the list of causes. Injury mortality data are available with ICD-10 classification to the 4th digit level (V/Y and S/T codes). The injury mortality data give information on: cause/mechanism (V/Y codes), intent and place of injury by body region (S/T codes) and other data (demographic data, place of death, autopsy). In order to improve the injury mortality data the death certificate has been complemented by additional questions and a narrative part that allows describing the circumstances of injury death.
Patient-statistical forms include hospital admission data with ICD-10 codes, classification to the 4th digit level (V/Y and S/T codes) and other variables (age, gender, length of hospitalisation, outcomes). The Patient-statistical forms are electronic and are filled by the hospital, then transferred to County Institutes of Public Health and subsequently to the Croatian National Institute of Public Health and finally collated by the National Hospital Discharge Database. Previously, high proportions of unspecified external causes were noted, this was reduced in recent years. In 2014, the share of unspecified external causes among all injuries was 16% which indicated further room for improvement of registration of external causes. Capacity building has been achieved by: continuing education of health professionals on the importance of improving surveillance; better expertise in the country, and the exchange of knowledge and experience nationally and internationally. Sources for other injury data are: primary health care and specialist health care received from out-hospital system; work related injuries, registry of disabled persons; databases at the Ministry of Interior (e.g. on traffic crashes or domestic violence); other Ministries (Social affairs; Health and Justice) that also collect data on violence.
Injury data from hospital emergency departments have not been analyzed at the national level. Future efforts will be focused towards the establishment of a trauma registry and new morbidity indicators (including injuries) on incidence and prevalence. Efforts are also undertaken to educate medical students and public health experts on the importance of improving the injury surveillance.

Montenegro

A multisectoral approach to injury and violence prevention in Montenegro involves partnerships between the Ministry of Health and a large number of other Ministries (Labour and Social Welfare, Internal Affairs and Public Administration, Justice, Education and Sport, Human and Minority Rights, Transport and Maritime) and other relevant sectors such as police, national statistics agency and NGOs. In 2012, the Ministry of Health adopted a regulation for the establishment of a trauma registry and in 2015 there was a new regulation on monitoring of health care quality specifying detailed instructions with performance indicators for evaluation. Injury mortality data is collected using ICD-10 codes with 3 digits, S/T codes. Hospital in-patient data is recorded partly electronically and partly on paper (Clinical Center of Montenegro and special hospitals) using ICD-10 to the 3rd digit. Mechanisms of injury can thus not be reported nationwide, but only by a few hospitals that use medical documentation to the 4th and 5th digit. The Institute of Public Health receives data on hospital discharge of individual patients in the form of minimum data set from injured patients. There is a planned progression to electronic format in the future. Injury data from emergency departments is registered only in the capital in a separate system. The need for a centralized and complete electronic information system was noted.

Republic of Moldova

The Republic of Moldova has adopted a number of intersectoral policy documents and regulations that facilitate the development of injury data surveillance systems. Measuring injury mortality and morbidity is important for research and policy practice. Injury mortality data can be disaggregated by sex, age and geographical region. The information is collected yearly at

three levels: the municipality, district and national level. A Statistics Bulletin including injury data is published by the National Bureau of Statistics. The National Centre of Health Management verifies the certificates of death and they then go from the Ministry of Health to the Ministry of Internal Affairs where different sources of injury data are integrated and then returned to the Ministry of Health. Data are shared between different agencies as paper reports (Ministry of Health, parliament, government and other ministries). The systems to collect mortality data, morbidity data and emergency department data are complete and reliable but at present they are processed manually. They are based on the ICD-10 classification, to the fifth digit, providing information also on the activity during the injury and the place of occurrence. There is sufficient analytic capacity to produce timely reports for prevention. There are some hospital based electronic health information systems but there is a need to increase this on a larger scale.

Romania

Mortality data are collected with ICD-10 classification, to the 5th digit. For injury morbidity data, the minimum dataset includes age, gender and diagnosis using the ICD-10 to the fifth digit and information on admissions are aggregated at national level. Disaggregated data are only available on request. Starting from 2016 Romania will introduce the electronic health card. Emergency department data are partially complete and reliable, since cases are registered only when the patient is hospitalised. While information on violence is available, there is no national report on injuries. A need to develop an emergency department based electronic injury information system was noted.

Serbia

Injury morbidity and mortality data are collected from several sources of information such as: health care, police, social welfare and Republic Health Insurance Fund and the Institute of Public Health in Serbia, and the Statistical Office of the Republic of Serbia. Injury morbidity and mortality is regularly reported in the Yearbook on Health Statistics by the Statistical Office of the Republic of Serbia. The Statistical Report on Road Traffic Safety in Serbia is prepared by the National Road Traffic Safety Agency. Mortality data are recorded with ICD-10 codes including obligatory the 4th and 5th digit. This data can be disaggregated by age, gender, ICD-10 group XIX (S00-T98) and violent deaths. Regarding morbidity, for hospital discharge data the ICD-10 classification 4th digit coding is used, while for injuries the 5th digit coding is obligatory. In the emergency department such patient data are only collected when hospitalized. Progress has been made in 2013 and 2014 in gathering data electronically by a higher number of health care institutions. The number of patients treated in emergency departments is not routinely monitored. A project on data collection on non-fatal cases of child maltreatment and neglect by means of a defined MDS was initiated in 2013 in 10 healthcare institutions and expanded in 2014 data to 84 healthcare institutions. These data are collected in a special database on abuse and neglect but are not representative of the national level yet. However, with a new law on medical documentation and records that was adopted in 2015, improvements on the routine collection of electronic minimum data set on injury from all hospitals and emergency departments are being made. Implementation starts in 2016 and it is expected that the quality of injury data will be improved as will the harmonization of data from different sources. There is capacity for data analysis. The lack of awareness and motivation among health staff was noted as a challenge.

DISCUSSION ON TRANSFERABILITY OF LESSONS FROM MINIMUM DATA SETS TO SOUTH-EASTERN EUROPEAN COUNTRIES AND THE WAY FORWARD

The concluding discussion focused on the transferability of lessons, and the development of a minimum dataset, using lessons from the Norwegian injury surveillance system and the IDB/JAMIE project. Countries who are able to register both injuries (mortality and morbidity) with ICD-10, chapter 20 (4^{th} and 5^{th} digit) in hospitals and emergency departments are well placed to use these injury data for surveillance to inform policy and monitor prevention programmes. Countries that do not have this system, should develop a MDS using the European or Norwegian data recording models. Electronic health records are being implemented in many countries and this presents an opportunity to develop data collection on a MDS for injuries in hospitals. Increased awareness of the importance of injury surveillance for prevention would be needed among health care staff involved in registration of data. Attracting greater financial resources for implementation remains a challenge. In order to achieve a more complete injury data collection, a stepwise approach was proposed. This involved using selected hospitals to champion and show case good quality data collection before rolling this out to more hospitals nationwide. Country presentations affirmed that progress had been made in injury surveillance systems in the past four years. There was a broad agreement that next steps:

- Intensify efforts in countries to collect better routine data on non-fatal injuries by using ICD-10 classification up to the fourth and fifth digit;
- In the absence of such systems, develop an injury MDS in hospitals;
- Use pilot hospitals as champions to take this forward;
- Take advantage of electronic data collection systems to introduce the MDS to collect data on injuries;
- Invest in staff training to enter data more completely and to produce surveillance reports;
- Use curricula such as TEACH-VIP to build capacity and advocate for the need for injury surveillance among medical students and health care staff.

Participants affirmed that they found the sub-regional workshop useful for their professional working in injury surveillance. The exchange of knowledge, sharing similar problems and solutions within the SEE context was an invaluable opportunity to reflect on how national systems could be strengthened. The wish to continue the international exchange of expertise, experiences and solutions was expressed.

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ANNEX 1. PROGRAMME

DAY 1:	**Thursday, 12 November 2015**
14:00-15:00	Welcome address by the Ministry of Health of Republic of Moldova
	Welcome address by Norwegian Directorate of Health
	Adoption of agenda, and programme (Dinesh Sethi)
	Introduction by participants and their expectations
15:00-15:15	Need and Update on Injury surveillance in Europe and SEE (ICD, ACE, GSRVP, GSRRS) (Dinesh Sethi)
15:15-15:45	Country presentations: an update from 2014
15:45-16:00	***Coffee break***
16:00-17:30	Country presentations: an update from 2014
17:30-17:45	Discussion
19:30	***Welcome dinner***
DAY 2:	**Friday, 13 November 2015**
9:00 – 9:20	The Norwegian injury surveillance system: transferability to SEE countries (Johan Lund)
9:20 – 09:40	JAMIE minimum dataset: strengths, weaknesses, challenges and opportunities for implementation at country level (Rupert Kisser)
10:00 – 10:30	Discussion on transferability of lessons to SEE countries
10:30 – 11:00	***Coffee break***
11:00 – 12:00	Practical examples from countries with success stories
12:00 -12:45	How can we advocate for the importance of injury surveillance for prevention among national and municipal policy makers? Panel discussion (Jakob Linhave, Dimitrinka Jordanova, Rupert Kisser, Johan Lund, Dinesh Sethi, with contributions from All)
12:45 – 13:00	Next steps and evaluation of workshop (Dinesh Sethi)
13:00	***Lunch and departure***

ANNEX 2. TEMPLATE TO DESCRIBE NATIONAL INJURY SURVEILLANCE SYSTEMS.

The Injury surveillance workshop for south-eastern European countries on 12-13 November is the fourth one in this series of workshops. This will provide an opportunity to take stock of progress made over the last four years. Focal points are requested to make 15 minute presentations with an emphasis on changes over the last year.

1. Mortality
   a) Has anything changed in the last year with regard to the recording, classification and completeness of injury deaths in the system adopted in your country (ICD IX or ICD X)?
   b) For countries using ICD X, is the classification to the 3rd, 4th or 5th digit level (S/T or V/Z codes)?

2. Hospital in-patient data
   a) How many injury patients are treated by hospitals as in-patients?
   b) Are you able to determine the mechanism or cause of injury for the majority of these?
   c) If so, is this to the 3rd, 4th or 5th digit using the ICD X?
   d) Are these injury data used for injury registration data monitoring?
   e) Which kind of data is collected? Which format is used?
   f) Is the system computerized? Who enters the data?
   g) What has changed over the last year?
   h) Are you able to provide such data on the numbers of injuries by cause that are admitted to hospital? If not, how would you obtain such data?

3. Emergency department data
   a) How many injury patients are treated by emergency department?
   b) Is there an injury data register that is used for monitoring?
   c) Is the system computerized? Who enters the data?
   d) If ICD X is used, in how many digits? Are the 4th digit (location) and the 5th digit (activity) used?
   e) Is the Minimum Data Set collected
   f) Have there been any changes in the last year?
   g) Are you able to provide such data on the numbers of injuries by cause that attend the emergency department? If not how do you obtain such data?

4. Please describe the present situation in your country with regards to the organization of collection of injury data at national level (which personnel is involved, are data collected on paper forms, electronic forms?) for:
   a) Emergency departments
   b) In-patients in hospital
   c) Are these data collated centrally to provide an over view of the problem of non-fatal injuries?
   d) Are these data reported in the annual health or other report?
   e) What are your strengths, weaknesses, threats/constraints and opportunities of the current system that you are using?
   f) Can you give one example or more examples of where injury surveillance data was used to take policy action?

5. Is data being shared between different sectors for example for road traffic injuries and for child abuse?

6. How have these SEE injury surveillance workshops helped you in terms of capacity, information exchange and policy priority?

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The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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Original: English