



**South-eastern Europe sub-
regional workshop:
“Improving capacity for injury
prevention through improved
injury surveillance”**

**Budva, Montenegro
21–22 October 2014**



Helsedirektoratet

Norwegian Directorate of Health

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DAY 1

OPENING

Within the WHO European Region unintentional injuries account for more than 500 000 deaths and 15 million disability adjusted life years (DALYs) lost every year. This constitutes a threat to the economic and social development of the Region.

Following two World Health Assembly (WHA) resolutions, injury surveillance and prevention has been given greater larger priority in the Region. The WHO Regional Committee for Europe resolution EUR/RC55/R9 on the prevention of injuries in the European Region and the Recommendation of the Council of the European Union of 31 May 2007 on the prevention of injury and promotion safety, have both placed violence and injury prevention on the public health agenda. Both European policies draw attention to the importance of surveillance as an integral first step in the public health approach to prevention. Improved and systematic injury surveillance systems are needed in Europe for policy development, advocacy, prevention programming and evaluation.

The Norwegian Directorate of Health's injury surveillance system successfully uses emergency department (ED) and hospital data sets to determine the burden of injuries and monitor prevention policy. Along with the Injury Data Base of the European Union, it is regarded as a model example of effective surveillance for other countries in the Region. WHO's TEACH-Violence and Injuries Prevention curriculum has modules to strengthen health systems capacity in injury surveillance and its widespread use would offer an opportunity to achieve this. Much would be gained by improving injury surveillance in countries through the exchange of technical expertise.

With this in mind, the WHO Regional Office for Europe organized the South-eastern Europe (SEE) sub-regional workshop "Improving capacity for injury prevention through improved injury surveillance" on 21-22 October 2014 in Budva, Montenegro, in collaboration with the Ministry of Health in Montenegro and the support of the Norwegian Directorate of Health. There were 24 participants, 16 from nine Member States of the SEE (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Montenegro, Republic of Moldova, Romania, Serbia, and the former Yugoslav Republic of Macedonia). Larger delegations participated from Norway as well as from the WHO Regional Office for Europe. The format of the meeting was a series of lectures followed by group work¹ (Annex 2).

Participants were welcomed by Dr Miodrag Radunovic, Minister of Health of Montenegro, Mr Nils Ragnar Kamsvåg, Ambassador from the Royal Embassy of Norway, Ms Mina Brajovic, Head of WHO Country Office in Montenegro, Mr Jakob Linhave, Norwegian Directorate of Health, and Dr Dinesh Sethi, WHO Regional Office for Europe. Professor Radunović stressed the Health Ministry's commitment to establishing an injury surveillance system and the need for a multidisciplinary response to address violence and injury.

INJURY SURVEILLANCE IN EUROPE

The first presentation by Dr Sethi focused on surveillance of injuries in the WHO European Region and some of the work in this area being led by WHO. Attention was drawn to the persistent inequalities in deaths between low- to middle-income countries versus high-income countries through time. The importance of complete and reliable data for deaths, hospital admissions and emergency department attendances was emphasised. The widespread use of the International Classification of Diseases, X revision (ICD X), 4th-5th digit coding (V-Y codes) presented an opportunity. The range of the existing data systems in the Region was described; there was great variation. Multiple data sources need to be used including those from the Police and Health sector. Collection for data for the *Global status report on road safety 2015* was progressing well with data being collected through questionnaires and assessment of national legislations from 52 participating countries. This was followed by the presentation of the first ever *Global Status report on violence prevention*. There were 41 countries (representing the 83% of the Regional population) from WHO European Region. A multisectoral consensus approach was used using data from multiple data sources. The report would be a baseline for the Global Violence Prevention Action Plan which would be developed in 2015. Data collected for the production of the *European report on*

¹The present report, which summarizes the results of the meeting, has been written by

*preventing child maltreatment*² provided the evidence for the launch of the European child maltreatment prevention action plan 2015-2020. A multisectoral approach, using extensive and systematic surveillance to monitor progress would be used to reduce the of child maltreatment. The importance of the new European Health Policy *Health 2020: the European policy for health and well-being* was emphasised as a framework for multisectoral action and the current calls for capacity building, in surveillance and data collection, stressed the need to share expertise and knowledge across sectors and countries.

INJURY SURVEILLANCE SYSTEMS: COUNTRIES PRESENTATIONS, AN UPDATE FROM 2013

The expert representatives of the nine participating Member States were asked to deliver a short presentation on the status of injury surveillance using a template (see Annex 4).

Albania

During the presentation it was underlined how injuries prevention is now considered a priority for the Albanian Government. However, the International Classification of Disease, IX revision (ICD IX) is still used, meaning that it is not possible to determine neither the mechanism nor the cause of the injury. There is now an official plan to switch to the International Classification of Diseases, X revision (ICD X), 4th-5th digit coding. A draft law for Emergency services and the development of a National Register for Emergency service data would lead to the creation of a standardized system for data collection was about to be ratified. This represented an opportunity for future comprehensive data collection. This would be an improvement on the current situation where data are still presented in hard copy, at second digit level and entered manually by two operators at the Ministry of Health.

Bosnia and Herzegovina

The Federation of Bosnia and Herzegovina³ has a health care and data system at entity (country) level, whereas monitoring and implementation systems are at cantonal level. This results in different level of implementation as it often depends on local funds. Overall, the Federation uses the ICD X, 3rd digit levels (S/T and V/Y codes). Injury-related mortality has seen an overall decrease in rates between the years 2008-2012, but traffic injuries remain the most common external injury cause. The collection of hospital admission data only started in 2013. The main issue is still the inexistence of structured software for data entry. Similarly, EDs are in need of improvements on the data collection front, as it is still based on paper copies. A new IT system is under development, and an official form has to be developed. The most pressing obstacles to be overcome in future are the development of linked data networks between emergency units, and the need of training in data collection and computerization.

Bulgaria

The statistical activity is carried out by the National Statistical Institute and the Department of National health Information and E-Health. The annual statistical information is produced via specialised software, meaning that all the data are computerised and that there is overall sufficient capacity at national level to produce timely reports for prevention. Bulgaria uses the International ICD X, up to the 3rd digit levels. The major change reported was the recent introduction of the 4th digit levels. The mortality records focus mainly on the cause, whereas hospital admissions records, which are submitted electronically monthly and filled by specialised data operators, do not specify the mechanism or the cause of injury. A similar situation is found in the EDs record and needs to be improved for comprehensive surveillance.

Croatia

The use of ICD X, 4th digit levels (S/T and V/Y codes) is established in Croatia, where the national coverage is supported by a well-known system and framework defined by law. Injury-related mortality records have further improved by the addition of complementary supplemental questions, including also a narrative section on the description of the circumstances of death. The presenter highlighted a generalised lack of resources, which resulted in the reduction of the number of autopsies and the presence of a high proportion of unspecified causes of injury (20.7%). This is because, despite the capacities of receiving the data from the hospital systems (collected in Patient Statistical Forms), there is a common lack of perceived need for accurate data entry among the hospital staff. The problem has been addressed and improvements should be seen via the implementation of a continued education and training of students and clinicians on the importance of monitoring. EDs are lacking a data collection

²<http://www.euro.who.int/en/health-topics/disease-prevention/violence-and-injuries/publications/2013/european-report-on-preventing-child-maltreatment>

³There was no representative from the Republika Srpska during this meeting.

system and thus the data analysis at national level is not possible at the moment. Improvements should be observed after the introduction and establishment of a trauma registry.

Montenegro

The Ministry of Health adopted a regulation and registration forms for the trauma registry, in accordance to the recommendations of the Institute of Public Health. Data are available with ICD X classification, 3rd digit level (S/T codes) for mortality data, and 4th-5th levels (S/T codes) are in use only for medical documentation for hospital admissions, medical records.. Otherwise 3rd digit level is used. Overall, the presentation highlighted the lack of centralised information system in collecting data, centralised data base. There is still extensive use of paper for data collection. Some improvements have been reached in the hospital admissions, where electronic forms are more used nowadays, but in the Emergency Departments doctors still have to manually enter the data according to the patients protocols. There is a need to improve monitoring and evidence of external cause coding and there will be an opportunity to do this when the country starts the integral informations health system on the all three health care level. It will be important to emphasise that 4-5 digit external cause coding (V/Y codes) is used for the medical documentations.

Republic of Moldova

Following the launch of the health care system development strategy and the national health policy, data showed that the trauma and poisoning incidence between the years 2010-2013 has decreased by 32%. Furthermore, records display a decrease in time of numbers of hospital admissions both among adults and children. Data are available with ICD X, 4th digit level (V/Y codes). The computerization of the data collection system allowed the extensive use and submission of electronic data. Among the country's progresses, in 2013 a Diagnosis-related Groups (DRG) financing system was implemented and a process of regionalization of paediatric emergency and intensive care services was implemented.

Romania

There is a reliable and complete system of data collection for mortality cases. Data, available with ICD X, 4th digit level, show a steady decrease of injury-related mortality by 39% between the years 1990-2013. All hospital admissions are reported according to a minimum dataset per case according to a DRG classification. The electronic system allows the aggregation of information at national level. EDs are not able to provide any information on the numbers of injuries, causes, or mechanisms. The information is collected in electronic ED forms. The need to improve the national collection system and the data sharing process between institutions is reflected in the absence of national reports about unintentional injuries, which are only available from different stakeholders.

Serbia

Injury-related mortality and morbidity data are obtained from a wide range of resources. This can be collated for publications and databases; there often is a disparity of data from different sectors. Data are available with ICD X, 5th digit (V/Y codes) level in Belgrade (with exception of mortality data, where the 4th digit level is still used). According to the data, injuries are the 5th cause of death in Serbia and the agent of 5% of all hospitalizations. Among the improvements, a set of new instructions for completing the report on hospitalizations, and trainings on data entering methods and report preparing. Moreover, the improved data entry and logistic control increased the reliability of the records. There is no injury data register in ED and only a small number of hospitals submit electronic copies of hospital admission data. These issues are to be improved in the near future as a result of a draft law on medical documentation and records in the field of health and a fully integrated and computerized Health Information System. This represents an opportunity.

The Former Yugoslav Republic of Macedonia

There is a long tradition of health –related legislations and regulations. One of the last promulgated was the law for evidence in health. Ten centres for public health have the responsibility of collecting, processing, and analysing the data for injury and violence. Data are available with ICD X, 4th digit level (5th in the soon to be introduced new form), S/T and V/Z codes, for both mortality and hospital admissions. There is no ED injury register and the data are only present in the EDs record books. The main obstacles reported in the presentation were the widespread underreporting and the poor data quality. This is the reflection of an overall lack of professional motivation among the hospital staff and a poor exchange of information between sectors. In order to overcome these issues, the on-going projects and goals include the implementation of an Integrated Health Information System, the development of National Software, and the introduction of a pilot web register for health and of the E-Health card.

A discussion followed the presentations. The lack of legislations and of motivation and knowledge of health professionals were identified as common constraints. As well, concerns were focused on the overload of hospitals. The dialogue continued on the necessity to introduce a proper legislative framework

and to improve surveillance via adequate education and engagement so to establish better governance mechanisms and support and data sharing among different institutions. There is an opportunity to improve surveillance with the new law.

USE OF ICD X FOR FATAL/NON-FATAL CASES IN THE SEE

All countries but Albania collect and register their data with ICD X, though there are serious attempts for the implementation of this last ICD revision. S/T codes, which describe the part of the body injured, are largely available throughout the SEE, but there is still a noteworthy percentage (up to 86%) of unspecified unintentional injuries and of undetermined intent. For example, between the years 2012-2014 14 assaults have been registered in Serbia, but 360 cases have been recorded under undetermined intent. Similarly, in the Former Yugoslav Republic of Macedonia 86% of the 419 recorded unintentional injuries are unspecified (2010), and 76% of the 111 unintentional injuries are unspecified in Montenegro (2009). These are just few examples to illustrate the strong need of a better and more extensive implementation of ICD X.

NORWEGIAN MINIMUM DATASET AND JAMIE

When the availability of data collected with ICD X becomes too poor to be reliable due to a range of reasons such as the large numbers of codes, low quality, and lack of interest from the hospital staff, a multifactorial minimum dataset (MDS) with fewer codes can be implemented at national level instead. This is the case brought forward by Professor Johan Lund from the Norwegian Directorate of Health, who described how Norway now relies on an MDS for all in- and outpatients in all the hospitals in the country. Despite some drawbacks like the slow development of an efficient electronic system which forces the hospital staff to use paper copies on occasions and the low capacity of the central system to analyse the figures, the dataset is more complete than the ICD X used to be and therefore more reliable for country statistics. The presentation then suggested the opportunities for the implementation of an MDS at country level while stressing once again the importance of data collection for the purpose of injury prevention and its positive effect on advocating multisectoral actions, and harness political interest and will and social support.

By the same token, Dr Kisser illustrated the minimum dataset of the European injury database (IDB). Being a slim and easy to complete system, it can be implemented with good results in most environments. Moreover, such system can be extracted from and compatible with other registries such as ICD. The implementing country could therefore have a reliable system with comparable indicators at national level, which, at the same time, does not require excessive staff training and funding. The possible weaknesses are the ones already presented both in the countries presentations and in Prof Lund's Norwegian overview: issues with computerized systems and the generalised lack of interest and will to commit among the hospital staff. The main suggestions were then to provide motivations to hospitals like additional benefits such the possibility of improved data exchange, or the prospect of introducing mobile applications or automatic coding to ease the burden of work on the staffers. This can be achieved with smaller and sustainable pilot implementations on the basis of other European experiences. Dr Kisser delivered a presentation on the Joint Action for Monitoring Injuries in Europe (JAMIE), a project funded by both the European Commission and the EU Member States, aimed at the establishment of a European injury surveillance system. JAMIE is now established in 26 countries, which are involved in annual meetings for the exchange of experiences and in the production of bi-annual reports. Owing to JAMIE, the adherent countries can extrapolate comparable national estimates and have a comprehensive and detailed view on injuries. Once again, the importance of injury data collection was accentuated highlighting the value of assessing the burden of injuries so as to promote prevention and rationally set priorities even in times of budgetary constraints.

Romania is one of the countries using the MDS for the IDB. This started under the JAMIE project with a pilot in the Children's Emergency Hospital in Cluj-Napoca. The project expanded and data (administered by the Babeş-Bolyai University), are collected regionally in four EDs using the IDB coding manual and software. Pilot analyses have focused on the sex and age of patients in relation to variables such as causes, activities, mechanisms, treatments, and risk factors. The results of this initial pilot already showed how a good dataset can move prevention forward and reset national priorities. It proved valuable for routine collection even in periods of budgetary constraints.

DAY 2

CHILD MALTREATMENT IN THE EUROPEAN REGION: THE ACTION PLAN AND DATA COLLECTION ISSUES

Dr Sethi introduced the results of the European report on preventing child maltreatment showing that the prevalence of child maltreatment is high in the WHO European Region, and that prevention activities such as educational parental programmes and improvements of social environments are beneficial throughout the child's life course. Evidence-based interventions have been accompanied by the improvement of surveillance systems, by a strong political commitment, and by multisectoral collaborations. All these actions require the development of budgeted national plans to coordinate action. Few countries have national prevention plans and interventions are limited in their implementations in several countries of the Region. Participants were encouraged to use the minimum data set from emergency department injury surveillance systems to monitor progress.

Four of the countries present in the SEE meeting have completed an adverse childhood experience (ACE) study in university and college students. According to the results, ACEs are common and have powerful negative repercussions on the risk of negative outcomes such as suicide attempts, alcohol and drugs abuse, or smoking. National experts described routine information systems.

ALBANIA

Data on child maltreatment are collected routinely from primary health care, hospitals, and EDs. Among the actions undertaken following the completion and the analysis of the ACE survey there are the Strategy for Health Promotion, the introduction of TEACH-VIP in the public health curricula, programmes aimed specifically at Roma children, and the implementation of life skills for teenagers programmes. Moreover, in the near future there are plans for the training of health professionals on injury surveillance. There is another survey in program for the years 2013-2014.

MONTENEGRO

The ACE survey conducted in Montenegro had a response rate of 98%. According to the results, abusive actions occur more often among boys than girls. The survey also investigated the most common household dysfunctions (violence against mother, 24%), and the repercussions of ACEs on behavioural attitudes (multiple partners, 41%, and early sex, 39%). The collected data remarked the evidence for which ACE have particularly serious outcomes on suicide attempts and alcohol abuse. The ACE survey was therefore the starting point for the development, implementation and monitoring of a multisectoral national action plan for the prevention of child abuse. This resulted in the improvement of data collection capacities and primary prevention systems via the integration of violence prevention into social and educational policies. A national policy dialogue is planned for 2015 to discuss the prevention plan and improved information systems.

SERBIA

In 2009 the country had a special protocol of healthcare system in children protection from abuse and neglect, but due to underreporting and poor availability of data the protocol was revised in 2013 and a MDS on abuse and neglect was created and piloted in the same year in 10 healthcare institutions. In 2004, the number of involved institutions increased to 84. More data were also available from other sources, but an ACE survey was needed to determine the prevalence of ACE and health risk behaviours among university students. Results (still unpublished) showed that corporal punishments and emotional abuse were common, with a higher exposure among males (with exception of physical neglect). There was a high prevalence of violence against mothers and increased risk of alcohol use and risky sexual behaviour. The survey will be used as evidence to improve the legislation framework and multisectoral collaboration, and to encourage further research in the field and in other spheres dealing with other vulnerable groups.

THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA

The improvements in the field of child protection and maltreatment prevention are based on the ACE study carried in 2010 and the BECAN study in 2013. As a result of the data extrapolated, a series of actions involving a systematic assessment of psychiatric morbidity and co-morbidity following a childhood trauma, the launch of a National Action Plan for prevention and protection of children from CAN 2013-2015, and a law on family violence in 2014. Moreover general and special protocols on children protection from abuse and neglect, on protection in social care and by the police were started in 2013, 2014, and 2009, respectively. Protocols in education, health and legal institutions are to be launched in

the near future. The future work will be focused on changing the personal perspective of the general public, monitoring at national and local level, and developing new institutions devoted towards child maltreatment.

SAFE COMMUNITY NOVI SAD, SERBIA.

Prof Mirjana Milankov presented the project of Safe Community started in Serbia in 2001, and is one of the 54 communities who are members of the European Safe Community Network. Based on the principles of information, education, training, changes in the physical environment, safety products, and changes in behaviours, the project offers workshops, seminars, reports, and presentations, and collaborates with the media. The projects are coordinated and widespread throughout the city and aim at increasing safety levels, improving the quality of life, and preventing injuries and violence. Prof Milankov highlighted the importance of better surveillance for injuries; currently data were collected manually but were essential for advocacy, evaluation and monitoring.

THE IMPORTANCE OF INJURY SURVEILLANCE FOR PREVENTION. PRACTICAL EXAMPLES OF SUCCESS STORIES: THE REPUBLIC OF MOLDOVA.

The Republic of Moldova is a good example within the SEE for the degree of improvement of surveillance systems. The Ministry of Health mediated the implementation of ICD X in 1995. Following the distribution of the Practical Guideline on population morbidity and mortality codification, the Ministry assisted and supported the change via national trainings on codification for all the involved professionals, the revision of all the university curricula, and the continuous education of hospital staffers. The political willingness, the introduction of an appropriate political framework, the existence of long-term health policies and strategies, and the implementation of medical facilities were key determinant factors for the overall enhancement of the country's capacities. The process progressed with the implementation of mandatory health insurance systems in 2004, and the implementation of DRG financial mechanisms in 2012.

PANEL DISCUSSION ON THE WAY FORWARD.

At the end of the day the participants engaged in a dynamic discussion on the strengths, weaknesses, and opportunities for further development.

Many positive changes have occurred in the SEE countries since the last workshop. Many countries such as Albania, Montenegro, Serbia and the former Yugoslav Republic of Macedonia were on the cusp of achieving much more comprehensive injury surveillance. There were challenges being faced in trying to implement ICD X (V-Y code) up to the 5th digit level. Part of this is the lack of health care staff awareness, volition, time constraints and resources. The development of a national MDS was suggested as a workable alternative to the ICD-10 in Emergency Departments, using the examples from Norway and IDB. Capacity building, advocacy, the use of data for prevention programming and computerization were suggested as possible solutions. In the debate on challenges and opportunities ahead the following areas were prioritised: to use Health 2020 as a policy leverage, to make links with the SEE Health Network, to advocate for improved injury surveillance for prevention, and to build capacity of health professionals and officials using curricula such as TEACH-VIP. The key messages shared by all the participants is the importance of data collection as a first step in the public health approach to prevention, and the powerful role that evidence-based information can play in advocating for policy change, to obtain political consensus and commitment, and to improve on multisectoral approaches. The meeting was rated very highly. The Norwegian Directorate of Health are thanked for their generosity.

ANNEX 1. SCOPE AND PURPOSE.

Every year injuries cause a significant number of deaths and human suffering in the WHO European Region, and pose a threat to the Region's economic and social development. Unintentional injuries are responsible for two-third of all injury deaths, accounting for some 500 000 deaths and 15 million disability adjusted life years (DALYs) lost.

Following two World Health Assembly (WHA) resolutions, injury surveillance and prevention has been given increased priority in the European Region. In line with these WHA Resolutions, Member States were invited to appoint National Focal Persons for injury prevention, with a view of facilitating the exchange of relevant information and experiences across the Region, and strengthening the regional and national capacity to advocate for injury prevention, promote evidence-based preventive strategies and develop cross-sectoral partnerships.

The WHO Regional Committee for Europe resolution EUR/RC55/R9 on the prevention of injuries in the European Region and the Recommendation of the Council of the European Union of 31 May 2007 on the prevention of injury and promotion of safety, have both placed violence and injury prevention on the public health agenda. Both these European policies emphasize the importance of surveillance as an integral first step to prevention. The 2010 report *Preventing injuries in Europe: from international collaboration to local implementation* shows that the resolution and recommendation have catalyzed action and that good progress is taking place. An increasing number of countries have developed national policies, strengthened their surveillance systems, and implemented evidence-based prevention programmes. The report highlights however a need for the health sector to commit to a more widespread and systematic approach to surveillance as a corner stone to underpin improved advocacy, policy development and evaluation.

In recognition that surveillance is an essential first step in the public health approach to prevention, the Norwegian Directorate of Health has developed an ED and hospital injury surveillance system which is being routinely used to monitor the burden of injuries and to evaluate prevention efforts. This is also fine tuned to also collate information on risk factors such as alcohol. In contrast many countries in the European Region do not have routine injury surveillance systems. WHO's TEACH-VIP curriculum has a module on injury surveillance in order to build health system capacity. Much would be gained by improving injury surveillance in these countries, and it is widely perceived that there is a need for the exchange of technical expertise and to ensure that capacity building actually takes place. A workshop held in October 2013 for this group of countries was rated highly and identified the next steps for action.

With this in mind, a one- and half-day workshop on injury surveillance will be organized on 21-22 October 2014 in Budva, Montenegro in collaboration with the Ministry of Health Montenegro and with the support of the Norwegian Directorate of Health.

Participants will be injury prevention and surveillance experts from countries from South-Eastern Europe. The workshop will use the TEACH-VIP injury surveillance modules and will incorporate injury surveillance expertise and technical know-how from the Norwegian Directorate of Health. The programme for the day will consist of lectures and small group working using interactive exercises and databases. It is hoped that there will be an exchange of expertise between participants from different countries and opportunities for networking. Participants will also discuss how injury surveillance can be mainstreamed into health professional training curricula.

Successful outcomes of the workshop would be to have a better institutional capacity for injury surveillance for prevention, with an improved understanding between sub-regional participants of the key advances being made in these areas, an agreement on the items for an injury minimum dataset for registration in hospitals and on how to improve the organization of data collection in hospitals and emergency units, and on how mentoring groups could be formed to facilitate capacity building and cross-country learning. The uptake of training materials developed into health professional curricula will be a measurable project outcome which will be monitored in successive years.

ANNEX 2. LIST OF PARTICIPANTS.

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ANNEX 3. PROGRAMME.

Monday, 20 October 2014

19:30 **Reception**

Tuesday, 21 October 2014

9:00 – 9:30 **Registration**

9:30 – 10:10 Welcome address by Minister of Health Montenegro
Welcome by WHO (Brajovic)
Welcome address by HE Ambassador Royal Embassy of Norway
Adoption of agenda, and programme (Sethi)
Introduction by participants and their expectations
Administrative information

10:10 – 10:30 Need and Update on Injury surveillance in Europe and SEE (ICD, ACE, GSRVP, GSRRS) (Sethi)

10:30 – 10:50 **Coffee break**

10:50 – 12:20 Country presentations: an update from 2013

12:20 – 12:50 Discussion

12:50 – 14:00 **Lunch**

14:00 – 14:15 Use of ICD X for non-fatal cases in WHO European Region (Mitis)

14:15 – 14:40 2 countries with examples ICD 10

14:40 – 15:00 **Coffee break**

15:00 – 15:30 Norwegian minimum dataset: strengths, weaknesses, challenges and opportunities for implementation at country level (J Lund)

15:30 – 16:00 JAMIE: results from 26 countries (R Kisser)

16:00 – 16:30 JAMIE minimum dataset: strengths, weaknesses, challenges and opportunities for implementation at country level (R Kisser)

16:30 – 17:00 Country examples with JAMIE (Romania)

17:00 **Close of scientific programme**

20:00 **COMING TOGETHER: welcome dinner**

Wednesday, 22 October 2014

09:00 – 09:05 Review Day 1

09:05 – 09:30 Discussion on key items for inclusion in the minimum dataset (Panel discussion: Linhave, Jordanova-Pesevska, Brajovic, Kisser, Mitis, with contributions from all)

09:30 – 09:40 Child maltreatment in the European Region: the action plan and data collection issues (Sethi)

09:40 – 10:30 Country presentations on child maltreatment using survey and hospital data

10:30 – 11:00 **Coffee break**

11:00 – 11:20 Safe Community Novi Sad, Serbia: the need for data (Mirjana Milankov)

11:20 – 11:30 How can we advocate for the importance of injury surveillance for prevention among national and municipal policy makers and attract greater resources? (WHO)

11:30 – 11:50 Practical examples from countries of success stories (MDA etc)

11:50 – 12:00 Next steps and evaluation of workshop

12:00 – 13:00 **Lunch and departure**

ANNEX 4. TEMPLATE TO DESCRIBE NATIONAL INJURY SURVEILLANCE SYSTEMS.

1. Mortality

- a) Has anything changed in the last year with regard to the recording, classification and completeness of injury deaths in the system adopter 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)?
- c) Has anything changed (improved or worsened in the last year)? If so please describe in a few bullets the main changes.

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) If ICD X is used, how many digits are routinely collated? Are the 4th digit (location) and the 5th digit (activity) used?
- h) Did anything change last year?
- i) 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) Have there been any changes in the last year?
- f) 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

5. Specify the data system you are using for

- a) Hospital admissions
- b) Hospital emergency department
- c) What are your strengths, weaknesses, threats/constraints and opportunities of the current system that you are using?

6. Do you collect data on non-fatal cases of child maltreatment and neglect on a routine basis from hospital and emergency departments and admissions for the prevention of injuries? How did you attract greater resources?

7. What other sectors provide routinely collected data on the incidence of cases of child maltreatment?

8. In your country do you have any examples of how you increased the awareness of the politicians and administrators (local or national) of the importance of injury surveillance from emergency departments and admissions for the prevention of injuries? How did you attract greater resources?

9. Do you have any suggestions in how such awareness and advocacy could be achieved in your country?

10. What advice would you give a neighbouring country as a way forward to increase the visibility of the injury problem?

ANNEX 5. EVALUATION OF THE QUESTIONNAIRES.

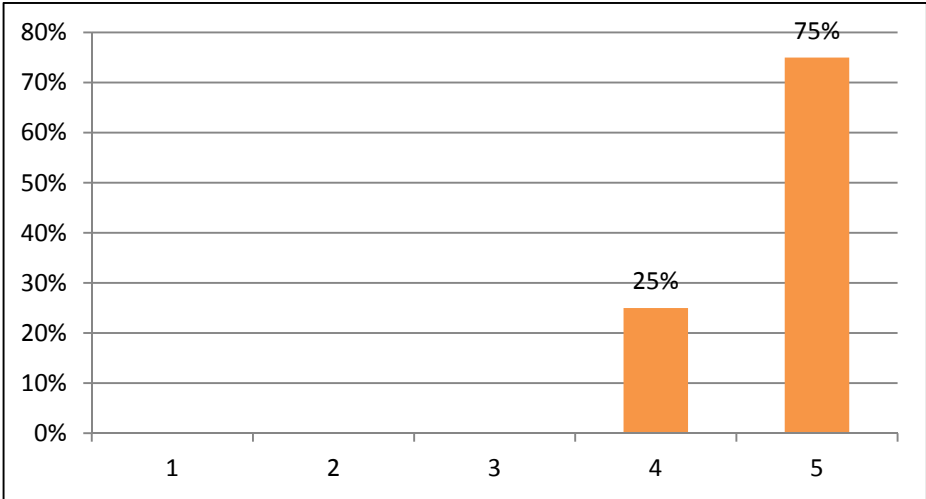
The workshop participants were asked to fill an evaluation form. The overall evaluation is based on the 16 forms received back.

The overall assessment was evaluated on a scale from 1 to 5, where 1 meant insufficient and 5 excellent. From Figure 1 it is possible to observe that 75% of the participants thought the meeting was excellent. In addition, 94% of the questionnaires stated that the workshop definitely achieved the programme objectives.

Similarly, all the participants agreed on the fact that the presentations delivered throughout the workshop met their expectations. In particular, participants appreciated the presentations on the Norwegian experience with MDS and the JAMIE project. Along with the exchange of positive experience and common challenges, the compatibility between ICD X and MDS was of certain interest. As a result, 81% of the questionnaires recorded that the information obtained will definitely useful for future work.

Suggestions for future meetings included the necessity to have shorter presentations so to allow more time for discussion and to have more instances of practical country-based examples. One participant also suggested a more insightful discussion on how to run national policy dialogues on the importance of collecting a minimum data set.

Figure 1: What is your overall assessment of this meeting (from 1=insufficient to 5=excellent)?



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