



**South-eastern Europe Health
Network sub-regional workshop:**

**“Improving capacity for injury
prevention through improved
injury surveillance”**

**Belgrade, Serbia
15–16 October 2013**

Keywords

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DAY 1

OPENING

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. 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. There is 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 emergency department and hospital injury surveillance system which is being routinely used to monitor the burden of injuries and to evaluate prevention efforts. 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 (Annex1).

With this in mind, the South-eastern Europe Health Network sub-regional workshop "Improving capacity for injury prevention through improved injury surveillance" was organized by WHO Regional Office for Europe on 15–16 October 2013 in Belgrade (Serbia) in collaboration with the Ministry of Health Serbia and with the support of the Norwegian Directorate of Health. There were 37 participants, including 10 focal persons from 9 Member States belonging to the South-east European Health Network (SEE) (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Montenegro, Republic of Moldova, Romania, Serbia and the former Yugoslav Republic of Macedonia). Larger delegations participated from Serbia and Norway as well as staff from the WHO Regional Office for Europe. The format of the meeting was a series of key note lectures followed by group work¹ (Annex 2).

Participants were welcomed by Professor Slavica Djukic-Dejanovic, Minister of Health of Serbia, Mr Nils Ragnar Kamsvåg, Ambassador of Norwegian Embassy in Belgrade, Dr Miljana Grbic, Head of WHO Country Office in Serbia, Mr Jakob Linhave, Norwegian Directorate of Health and Dr Dinesh Sethi, WHO Regional Office for Europe. The detailed programme is attached in Annex 3.

USING SURVEILLANCE FOR PREVENTION IN NORWAY

The first session focused on the Norwegian injury surveillance system and lectures were delivered by Johan Lund, Morten Støver and Håkon Haaheim (Norwegian Directorate of Health).

Johan Lund described the main components of a surveillance system and the burden of injuries in Norway. Two examples of surveillance systems, one based on a local minimum dataset and one on a more comprehensive dataset, were presented as case studies. Complete data collection, physicians and health workers who monitored trends and proposed preventive measures, working closely with municipal authorities and local organizations, including nongovernmental organizations were identified as key factors for successful injury surveillance systems for prevention.

Morten Støver described the current injury surveillance system in Norway. Registration of the Norwegian injury dataset has been mandatory at 24 hospitals and 3 emergency clinics since 2009. The data are quick and easy to enter and take approximately 1-2 minutes to register. Variables include date, time, place and

¹The present report, which summarizes the results of the meeting, has been written by Francesco Mitis, Dimitrinka Jordanova Pesevska and Dinesh Sethi (WHO Regional Office for Europe) and reviewed by Rupert Kisser (Kuratorium für Verkehrssicherheit), Johan Lund (Norwegian Directorate of Health), Trudy Wijnhoven and Josephine Jackisch (WHO Regional Office for Europe).

cause of injury, activity when injured, injury mechanism, severity of the injury, mode of transport in the case of road traffic injury and map coordinates of the event. Each entry has a unique identifier and can be linked to other data sets within the Norwegian Patient Register, or to other Norwegian registers.

Håkon Haaheim briefly described the Norwegian Patient Registry showing which data are collected with a person identification number (PIN) code and how this has changed across the years. He ran a model to demonstrate the utility of tools for data visualization. An example of historical data of road traffic injuries in the city of Oslo was used to present the application of Geographical Information Systems in the dynamics of crashes according to day of the week, time, the place of the crash, and the response time of emergency services. Such information had been used to identify critical points for successful intervention, both in terms of prevention and response times. Quality and security requirements in the data collection chain, from registration, storage, reporting and use were specified.

INJURY SURVEILLANCE SYSTEMS: COUNTRY EXPERIENCES

The focal persons of participating countries were asked to deliver a brief presentation summarizing the status of injury surveillance in their country using a template (see Annex 4).

The following national injury surveillance systems were briefly described.

Albania

Injuries are the leading cause of death in the country. Road traffic injuries are the lead cause, above all for the people aged 25-44. Data are collated from hospitals, police, Ministry of Transport, research institutes and health insurance. Data by age, gender and region are available but reporting is paper-based. Several attempts have been made to introduce the International Classification of Disease, X Revision (ICD X) classification into the country, but without success. Albania still uses International Classification of Disease, IX Revision (ICD IX). An annual report from the Institute of Statistics includes information on injuries. Information is shared and there are good relations across sectors, above all for road traffic injuries and for violence prevention.

Bosnia and Herzegovina

In the Republic of Srpska, multiple sectors are involved in injury surveillance uses multiple sectors. Data are gathered from health centre's monthly activity reports, individual hospital report data sheets, reports on occupational injuries, the annual report on the Health Status of the Population in the Republic of Srpska and from Demographical Statistics Bulletin. Mortality data are available and can be disaggregated by gender, age, region and year with ICD X classification. Injuries are reported with S and T codes, which describe the part of the body injured, and not with V/Y code which describe the mechanism. For morbidity data, ICD X is used, mostly with three digits and data collection and reporting are paper-based. There is a need for increased capacity for data collection and analysis. Injury data are not regularly shared but available only upon request, with the exception of road safety data that are shared across sectors.

In the Federation of Bosnia and Herzegovina the situation is different and data are collected at canton level. Better coordination is needed. A trauma registry, restricted to orthopaedic injuries, is being implemented in collaboration with the University of Iowa.

The whole country delivered mortality data to WHO for the first time in 2012. This is an important achievement, but a lot of work on data quality is needed.

Bulgaria

Injuries are the fifth cause of death in the country and are the second cause of death for people aged 20-24. Data are gathered from the health sector, from sickness certificates, police, and from the information systems on occupational injuries. Both mortality and hospital admission data are available using ICD X codes, at three digit level, while emergency department data are collected and coded using ICD IX. Data are computerised at point of entry using specialized software. A sufficient analytic capacity to produce timely reports for prevention is available. In road traffic injuries data are combined from police and health sector and a probabilistic linkage of data records is used. Injury data are shared across different agencies. Data are accessible through a written request and most of them are published in annual reports.

Croatia

Injuries are the third cause of death in the country. Amongst these, the leading cause of death is falls (35.3% of the injuries, followed by suicides and road traffic injuries). Mortality and morbidity data are available with ICD X code since 1995. Mortality data are provided with four digits, giving reliable

information on the mechanism, intent and place of injury, disaggregated by gender, age and region. Morbidity data are collected in electronic format and provide information on hospital admission, including at day hospitals. Registration needs to be improved since a high proportion of unspecified external causes has been noted. Data collection on injuries from hospital emergency departments does not exist but some initial steps have been taken. Analytical capacity to produce timely reports for prevention is insufficient due to the lack of human and technical resources. Data are collected from several sources and are regularly shared across sectors.

Montenegro

Work on violence and injury prevention is done at multisectoral level under the coordination of the Ministry of Health. Mortality data are available with ICD X code, three digits. They are published by the Institute of Public Health on the Statistical Yearbook and they are available for the last six years, disaggregated by gender and age group. Morbidity data are provided by the public health institutions and are classified according to ICD X code. Additional data are provided by the Police Directorate and by the Governmental Statistical Agency MONSTAT. Information on criminal offences is provided using judiciary data and by MONSTAT. A centralised electronic system for the collection of injury data is not available yet.

Republic of Moldova

The systems to collect mortality data, morbidity data and emergency department data are complete and reliable. They are based on ICDX classification, to the fifth digit, providing information also on the activity during the injury and the place of occurrence. Data are shared across different agencies and there is sufficient analytic capacity to produce timely reports for prevention.

Romania

Mortality data are collected with ICD X classification, to the fifth digit. For morbidity data, the minimum dataset includes age, gender and diagnosis codified by ICD X to the fifth digit and information on admissions are aggregated at national level. Disaggregated data are only available on request. Emergency department data are partially complete and reliable, since cases are registered only if the patient is hospitalised. While information on violence is available, there is no national report on injuries.

Serbia

Data for injuries are gathered from different sectors (health, police, social welfare, insurance) and there is no unique database. Mortality data are collected according to ICD X classification but registration is not optimal since a lot of undetermined injuries are reported. Several data sources are available for morbidity. For hospital admissions ICD X, to four digits is used. In the emergency department the patient is registered only if hospitalized. Data exist but its quality needs to improve and data from different sources need to be harmonized. Analytic capacity is present but there is a lack of awareness on the importance of injury prevention and more financial support is needed.

The former Yugoslav Republic of Macedonia

Ten centers for public health collect, process and analyse data for injury and violence in the country, under the coordination of the National Institute of Public Health. WHO injury surveillance coding is applied in the country. Mortality data and hospital admissions data are collected according to the ICD X classification, to the fifth digit. However the system is neither complete nor entirely reliable, due to underreporting and to missing data for external causes. There is sufficient analytic capacity for reporting but poor exchange of primary information between sectors.

This brief session revealed that the situation is quite heterogeneous across the SEE countries. Whereas all the countries but one (Albania) use ICD X, only three of them (Republic of Moldova, Romania and the former Yugoslav Republic of Macedonia) use it to the fourth and fifth digit. Bosnia and Herzegovina use ICD X with S and T codes, which record the consequences of injuries and not with V/Y codes (which record the injury mechanism). Some commonalities were: (i) data are collated from different sources; (ii) only in-patients and not patients visited in emergency rooms are registered; (iii) there is a high proportion of injuries coded as non specified external causes; (iv) with the exception of the former Yugoslav Republic of Macedonia, there is not enough capacity to produce timely reports due to lack of human resources and policy priority; (v) the quality of data needs to improve.

BREAK OUT SESSION 1

In this session groups were asked to perform a SWOT analysis on the following three topics:

1. *Organization for data collection and workload in the hospitals.* Constraints identified were the lack of legislation and the lack of motivation and knowledge on the part of health professionals. In addition to that, a common concern is that hospitals are overloaded. Proper legislation at national level and awareness raising of staff of the importance of surveillance through better education and engagement through shared feedback is needed.
2. *Tools for data collection – hardware and software.* The importance of legal requirements was debated. Better use had to be made of existing data with better standardization. Financial incentives for data collection were not sustainable, but support was needed in terms of health information systems. Some countries needed better governance mechanisms to allow data sharing.
3. *Surveillance for action: staff and analytic capacity and timely response.* Availability and accessibility of data and bureaucratic impediments were discussed. Data sharing and analysis may be influenced by political priorities, and governance frameworks were needed, including those that allowed data sharing whilst protecting confidentiality. There was a certain amount of duplication which could be circumvented by better data sharing. Ownership of data was felt to be important to improve motivation.

USING MORTALITY AND HOSPITAL ADMISSION DATA FOR SURVEILLANCE

Francesco Mitis (WHO Regional Office for Europe) delivered a presentation on WHO databases freely available on the web. After a short introduction of the WHO Health for All Mortality Database, more emphasis was given to the European Detailed Mortality database, describing data classified according to Mortality tabulation list 1 of the ICD X (MTL1), ICD IX and ICD X codes. Demonstrations were given of how to (i) produce country profiles, (ii) create aggregated variables, (iii) obtain age standardized mortality rates, (iv) analyze trend data, to produce charts and to export tables and results for selected countries and variables, and (v) investigate ICD X codes to better understand circumstances and mode of deaths within the same cause. This is available for all SEE countries (except Albania), but less so for countries in the eastern part of the WHO European Region.

The hospital admissions detailed database was introduced. Particular attention was given to variables as hospital discharges, day-cases, number of bed-days, average length of the admission. Links to use and download online versions of databases were shared and included the Global Burden of Disease Project and the Inequality Atlas.

INJURY SURVEILLANCE USING EMERGENCY DEPARTMENT DATA AND THE INJURY DATA BASE

The lecture by Rupert Kisser (Kuratorium für Verkehrssicherheit) covered the European Injury Data Base (IDB) and described how most European Union (EU) countries now had hospital emergency departments that collected the minimum data set on injuries. Data for 12 countries were available in 2010; for 17 countries by 2012 and 5 additional countries were expected to deliver data by 2014. However the level of implementation is variable in terms of significance of the sample used and on quantity and detail of data collected.

The importance of focusing on non-fatal injuries was stressed. Road traffic and workplace comprise only 20% of non-fatal injuries in EU27; the remaining 80% of injuries representing almost 32 million people would only be captured through more comprehensive injury surveillance. These represent a burden for the health sector.

Both the Resolution on the prevention of injuries in the WHO European Region (EUR/RC55/R9) of 15 September 2005 and the EU Council Recommendation on the prevention of injury and the promotion of safety of 31 May 2007 promote injury surveillance and use of existing data to better understand the causes and consequences of injuries.

The IDB promoted the collection of a minimum dataset in emergency rooms for all hospitals and an expanded dataset for reference hospitals. Data were rarely collected at the fourth and fifth digit level in a comprehensive way. Basic information for prevention were therefore missing in many countries and has to be improved.

The Joint Action on Monitoring Injuries in Europe (JAMIE) project protocol is trying to remedy this in EU countries by promoting the collection of a minimum dataset for injury data in emergency departments.

After the lecture group work consisted of hands on exercises using data from the IDB.

DAY 2

SURVEILLANCE SYSTEMS USING COMMUNITY SURVEYS – MULTICOUNTRY ACE STUDY

Dr Dinesh Sethi presented a lecture based on the WHO TEACH-VIP curriculum on how community surveys could be used to obtain a more comprehensive picture of injuries and violence. Surveys complement the existing information or fill in gaps where reliable and complete information are not available. Household surveys could be used to obtain estimates of the magnitude, scope and characteristics of an injury problem, identification of risk or protective factors associated with certain individuals or communities. They were particularly useful to obtain estimates of violence where this may not come to the attention of health professionals, as illustrated by the use of multi-country surveys of adverse childhood experiences. The use of standardised tools and methods enabled intra- and inter-country comparisons and could be applied at different points in time. The European report on preventing child maltreatment² defined child maltreatment as a common and leading public health problem. The abuse can be fatal, leading to 852 deaths of children under 15 years every year. Deaths are only the tip of the iceberg. The report, released at the sixty-third session of the WHO Regional Committee for Europe, estimates that the prevalence of maltreatment is much higher, ranging from 29.1% for emotional abuse, 22.9% for physical abuse, to 13.4% for sexual abuse in girls and 5.7% in boys. Prevention is more cost-effective than dealing with the consequences of maltreatment. The use of surveys had helped identify the scale of the problem and were being used to advocate for policy action.

ACE SURVEYS: RESULTS FROM COUNTRIES

The focal persons of the participating countries presented the main findings of Adverse Childhood Experiences (ACE) surveys and the national policy response. ACE surveys were presented from Albania (ALB), Montenegro (MNE), the former Yugoslav Republic of Macedonia (MKD), and Romania (ROM). Serbia (SRB) is in the process of conducting such a study.

The prevalence rates for physical abuse vary from 44.4% for males and 40.1% for females (ALB), 24.8% for males and 23.8% for females (MNE); 22.3% for males and 20.2% for females (MKD) and 27.5% for males and 26.6% for females (ROM). The prevalence rates of emotional abuse vary from 51.1% for males and 51% for females (ALB) 33.3% for males and 27.5% for females (MNE); 9.5% for males and 11.7% for females (MKD); and 21.5% for males and 24.9% for females (ROM).

Sexual abuse has the following prevalence rates: 8.8% in males and 4.7% in females (ALB); 6.8 for males and 1.5% for females (MNE); 20.8% for males and 7.3% for females (MKD); and 5.6% for males and 10.9% for females (ROM).

In these four studies the highest rates for prevalence of household dysfunctions have been found for mother treated violently and alcohol misuse. Exposure to more ACE categories was strongly associated with health risk behaviors (early smoking, illicit drug use, multiple sex partners, unwanted pregnancies and suicide attempts).

ACEs studies in the countries have facilitated national policy dialogues on child maltreatment; development, implementation and monitoring a national multisectoral action plan for the prevention of child maltreatment in MKD. In other countries these have resulted in greater policy priority being given to the area, with awareness raising, an increased focus on prevention (primary, secondary, tertiary) and demands for capacity building regarding child maltreatment.

ROUND TABLE DISCUSSION ON WAYS FORWARD ON INCREASING CAPACITY

The following priorities needs were identified by the participants:

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

- implement uniform but inexpensive surveillance systems;
- improve coding, particularly for injuries due to violence;
- better recording and wider dissemination of information on non-fatal injuries;
- greater emphasis on improving injury surveillance systems in the eastern part of the Region;
- continue the international exchange of expertise, experiences and solutions;
- use curricula such as TEACH-VIP to build capacity and advocate for the need for injury surveillance;
- find common approaches to motivate health personnel to collect data in hospitals; and
- achieve better coverage of external causes in order to guide targeted prevention actions and to monitor the eventual impact of such targeted actions.

Participants found the present workshop useful to further their professional expertise in injury surveillance. The exchange of common problems and solutions in the similarity of the SEE context was found invaluable. For the next subregional meeting the following focus was suggested:

- a proposal of an injury minimum dataset for registration in hospitals and agreement on classifications and definitions to be used in the Region;
- how to increase the awareness of importance of injury surveillance for prevention in the political and administrative areas and attract greater resources; and
- how to improve the organization of data collection in hospitals and emergency units.

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. There are around 50 countries with National Focal Points for injury prevention 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 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 emergency department 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.

With this in mind, a one- and half-day workshop on injury surveillance will be organized on 15-16 October 2013 in Belgrade, Serbia in collaboration with the Ministry of Health Serbia and with the support of the Norwegian Directorate of Health. Participants will be injury prevention focal persons 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, with an improved understanding between sub-regional participants of the key advances being made in these areas, on how mentoring groups could be formed to facilitate capacity building and cross-country learning. The uptake of these lessons into health professional curricula will be a measurable project outcome which will be monitored in successive years.

ANNEX2: LIST OF PARTICIPANTS

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ANNEX 4. PROGRAMME

Tuesday, 15 October 2013

9:00 – 9:30	<i>Breakfast and registration</i>
9:30 – 10:00	Welcome address by Ministry of Health Serbia Welcome by WHO (Grbic) Welcome address by Norwegian Directorate of Health (Linhave) Adoption of agenda and programme (Sethi) Introduction by participants and their expectations Admin and practical information
10:00 – 10:40	Key-note : Using surveillance for prevention in Norway (Lund, Stover, Haaheim)
10:40 – 11:00	Coffee break
11:00 – 12:30	Country presentations from each of 9 countries of 10 minutes
12:30 – 13:00	Facilitated discussion using TEACH VIP module on surveillance (Sethi, Jordanova)
13:00 – 14:00	Lunch
14:00 – 14:30	Break out session 1
	1. Organization for data collection and workload in the hospitals (Stover) 2. Deliverance of the software (Haaheim) 3. Staff capacity and timely response (Lund)
14:30 – 15:00	Plenary discussion
15:00 – 15:30	Using Mortality and Hospital Admission data for surveillance (Mitis)
15:30 – 15.45	Coffee break
15:45 – 16.15	Injury surveillance using Emergency Department Data and the Injury Data Base (Kisser)
16:15 – 17.30	Break-out session 2 Exercises on data interpretation (Kisser) <i>Lets get together – welcome drinks and social dinner</i>

Wednesday, 16 October 2013

09:00 – 09:05	Review Day 1
09:05 – 09:30	Surveillance systems using community surveys – multicountry ACE study (Sethi)
09:30 – 10:30	Country examples from ROM, MNE, MKD, SRB
10:30 – 10:50	Coffee break
10:50 – 12:00	Round table discussion on way forward on increasing capacity Forming a network for surveillance
12:00 – 12:30	Course evaluation and close Lunch

ANNEX4. TEMPLATE TO DESCRIBE NATIONAL INJURY SURVEILLANCE SYSTEMS

1. Mortality: is the system complete, reliable, gives information on cause/mechanism, intent, activity, place; does it use ICD9/10, to what digit (3 or 5)? Does it provide national information disaggregated by age, sex, region?
2. Hospital admission: is the system complete, reliable, gives information on cause/mechanism, uses ICD9/10, to what digit (3 or 5)? Does it provide national information disaggregated by age, sex, region?
3. Emergency department: is the system complete, reliable, gives information on cause/mechanism, uses ICD9/10, to what digit (3 or 5)? Does it provide national information disaggregated by age, sex, region?
4. How is data collection organized: from Emergency Department, Hospital, Central statistics office?
5. What tools- software (e.g. ICD 10) and hardware (is it computerised at point of entry etc) are available?
6. Is there sufficient analytic capacity to produce timely reports for prevention? If yes give specific examples.
7. Are data shared between different agencies (e.g. police, health, social welfare)?

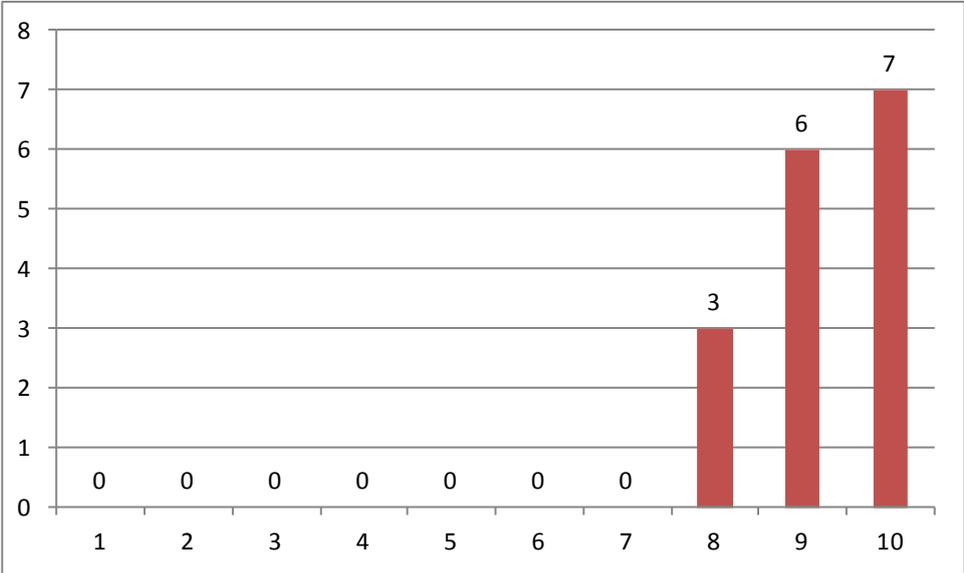
ANNEX 5. EVALUATION QUESTIONNAIRE RESULTS

Seventeen evaluation forms on the workshop were received back and final overall evaluation was given in sixteen of them. The participants assessed the meeting to be either good (3), very good (6) or excellent (7) (they assessed the meeting as 8 or above, on a scale of 10) (Figure 1). All the participants agreed or strongly agreed that the workshop content was related clearly to its objectives, that the details provided during the workshop were appropriate, as well as the workload and the utility of the information delivered. One participant disagree that the workshop was relevant to his/her professional needs and that the level of difficulty was appropriate.

All the issues treated were appreciated but particular preference was given to the description of Norwegian injury surveillance system, to the organization of the workload in the hospital and to staff motivation and to the exercises conducted with IDB. The session on community surveys was also particularly appreciated.

One participant asked to have more time dedicated to the methodology of the minimum dataset and to the use of its data. Another one would have liked to have more interactive exercises and hands on practices. On the logistic side, everything was appreciated, organization and accommodation. However, one participant said that break out sessions should have been better organized.

Figure 1. What is your overall assessment of this meeting? (from 1=insufficient to 10=excellent)



Note: 16 respondents

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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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