



WHO Collaborating Centre on Community Safety Promotion

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STOVNER DISTRICT'S APPLICATION FOR SAFE COMMUNITY STATUS

Based on WHO's 12 criteria, the district of Stovner is applying to be awarded "Safe Community" status

This application is built up in points corresponding to each criterion.

1. *Formation of a cross sectional group which is responsible for the injury prevention*
2. *Involvement of the local community network.*
3. *The programme will address all ages, surroundings and situations.*
4. *The programme will address the concerns of high-risk groups (such as children and the elderly), high-risk environments and aims to ensure equity for vulnerable groups.*
5. *The programme should have a mechanism to document the frequency and causes of injury.*
6. *The programme must be a long- term approach, i.e. not one of short- term duration.*
7. *The programme evaluation should include indicators, which show effects and provide information on the process as it advances.*
8. *Each local community will analyse its organisations and their potential for participation in the programme.*
9. *Participation of the health care community in both the registration of injuries and the injury prevention programme is essential.*
10. *Be prepared to involve all levels of the community in solving the injury problem.*
11. *Disseminate information on the experience both nationally and internationally.*
12. *Be willing to contribute to the overall network of "Safe Communities".*



SAFE LOCAL COMMUNITIES AND STOVNER DISTRICT

For many years the district of Stovner has laid emphasis on preventive health care throughout the various services in the district. We wish, therefore, to show that we work within the framework of that which is required for Safe Communities and thereby gain status of “Safe Community”, as defined by the World Health Organisation.

Prevention of injuries in its full breadth and cross-sectional organisation is the World Health Organisation's (WHO) concept for Safe Communities. Within this concept, we recognise the district's method of carrying out preventive work. To work in a broader aspect does not ensure success in all areas, although it does ensure that something is successful and can be implemented in the daily running of things. Measures which prove to be unsuccessful, form the basis of further efforts after the methods have been considered.

Safe Local Communities as a method, implies organisation activating local potential, initiating remedial actions, small and large, towards the prevention of injuries, which central organisations would have problems in handling efficiently.

Our work within accident prevention is carried out systematically in accordance with the Safe Community's guide lines (ref. Criteria, pt.1-12) and we see that the work can be carried out indefinitely, adjusted to the changes and resources of the community.

The choice of focal areas, especially within injury prevention work, is also dependent on new “trends”. For example, this is particularly the case of sports activities. Information on the frequency of injuries in this area can be obtained from the registration work at the casualty clinics where one can observe that the occurrence of injuries can vary according to the district and the sports activities available.

The way in which the district intends to fulfil the 12 criteria for Safe Community status, is handled thoroughly in the application, which is divided into 12 “chapters”, one for each of the criterion. Prior to this, a description of the district is given to provide an understanding of the framework and to make it possible to assess the preventive work which is being done. No particular funds have been earmarked for accident prevention work in the district, neither manpower nor financial.

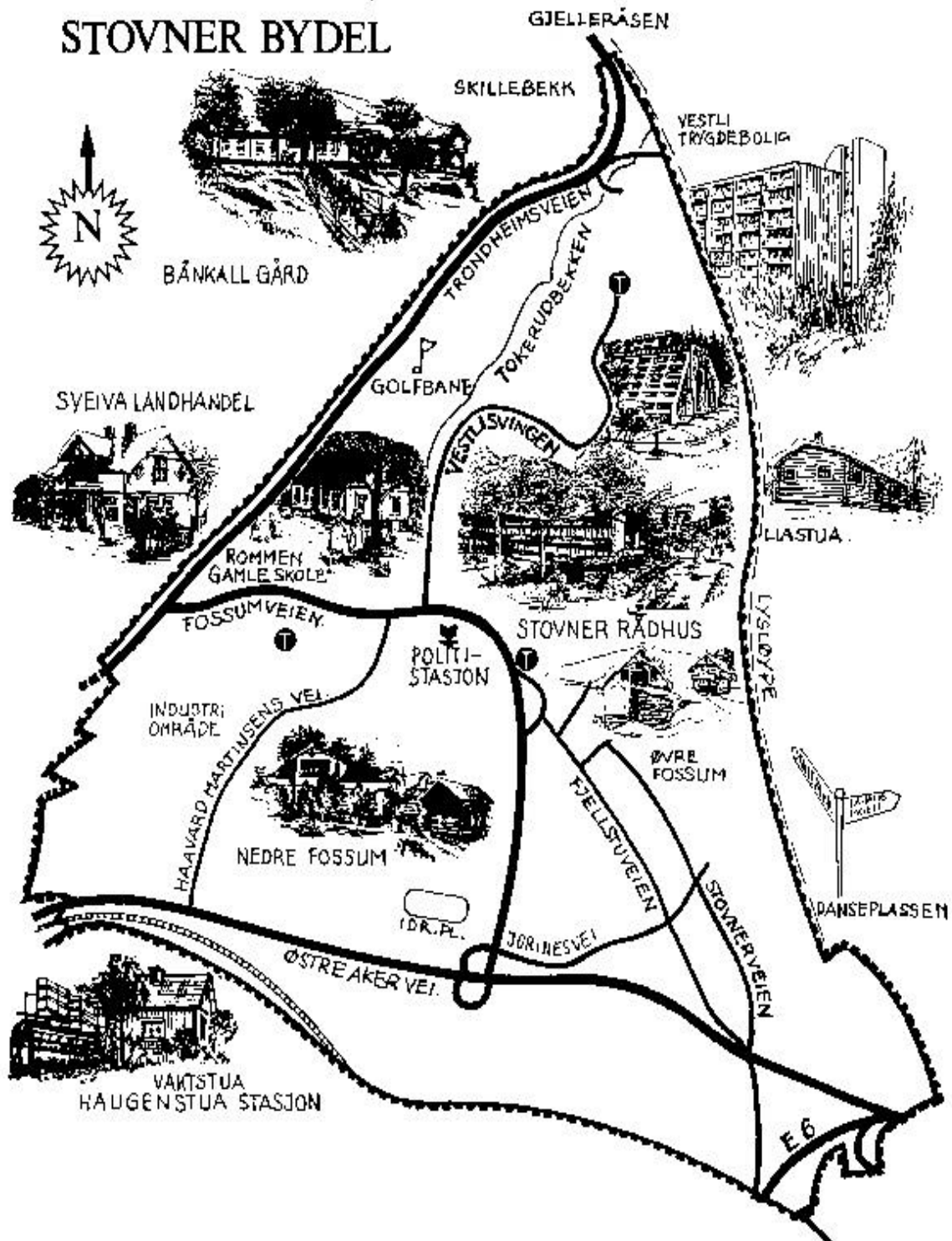
Injury prevention work began already in 1989-90 with focus on prevention of falls and fall-related accidents suffered by elderly people living in their own homes. It was then increased in 1993 to include all citizens as the target group (ref. pt.4 in the criteria). The work was carried out as a project throughout 1994, after which it became an integrated part of the work at the various locations offering services. One can conclude from this that the injury prevention work can be called a programme with a long-term perspective according to pt.6 in the criteria for Safe Communities.

The district has met the requirement of Safe Communities criteria, point 11, throughout recent years by hosting visits and the staff has visited other communities / services in Norway and abroad for the purpose of spreading knowledge from local experiences within injury preventive work.

This application can deviate from other districts' applications due to Stovner district's singularity and infrastructure. Stovner is geographically small, but with a population which is equal to Harstad, Norway's first “Safe Community”. The district has no traditional town road infrastructure.

INTRODUCTION WITH A DEMOGRAPHIC DESCRIPTION OF STOVNER DISTRICT.

Stovner district is one of 25 districts in the City of Oslo. The district lies towards the north east and is bordered by 3 other districts in Oslo, as well as 3 municipalities in the County of Akershus.



Population.

The district has 20,968 inhabitants, including 22% from other cultural backgrounds (*). A larger number of families with children live in the district than is average for Oslo and single households are also over- represented in relation to the average for Oslo. Thus, the average number of elderly people is less, although this is increasing.

(* Immigrants are defined as persons born abroad with two foreign parents born abroad, also persons born in Norway with two foreign parents. This creates a concept of immigrants according to ethnic origin, unrelated to citizenship. Children from abroad adopted by one or two Norwegian parents are not defined as immigrants.

Housing.

Stovner is a “relatively young” district. 70% of the 10,000 homes are built after 1970. Types of housing and population are divided such that 57% of the population live in blocks of flats, 32% in rows of terraced houses and 10% in detached houses.

Level of Education.

The level of education in the district is generally low compared to the rest of Oslo, but this is improving. 30% of the district’s population over 16 years of age does not have education over the basic schooling (10 years). Those with higher education at college/university level amount to 15%.

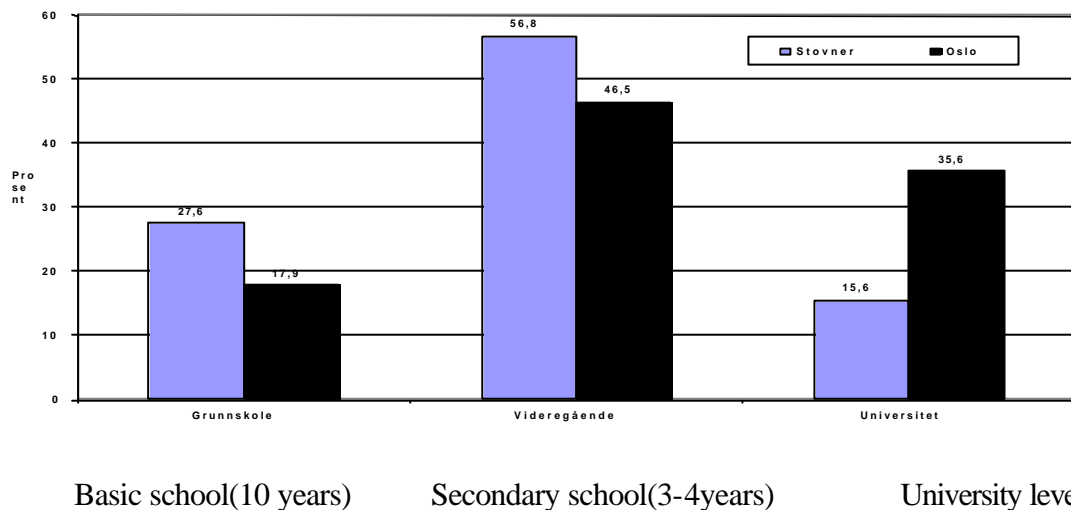


Figure 1: The highest level of education in % pr. 1.1.99 in Stovner and Oslo

Work and Income.

In the district of Stovner, private and community services provide together the greater number of working places available. A total of 35% of the working population is engaged in this type of work. Other large groups occur in the commodity trade plus the hotel and restaurant trade with a total of 25%, and 15% working in industry..

Within the age group of 16 – 66 about 9,5% are receiving invalidity benefit.

It is positive that there is little unemployment, as in Norway in general.

Nature and Environment.

The district has a well planned system of walkways for pedestrians and cyclists, including nature walks through the green belts. Although the district may appear to consist of a large amount of blocks of flats, there is also a fairly large percentage of terraced houses with gardens

and detached houses than is average for Oslo. The built up areas are softened up by green areas and play areas which fit into the natural outline and mountain formation of the district. There are paths through the forest which are well illuminated for cross-country skiing and nature walks after dark.

In the forest, at Liastua (a sports cabin offering refreshments), an area has been built out to provide a winter sports area for sledging, snowboarding and slalom skiing. In the autumn of 2000, an obstacle track was established. The local sports club, Høybråten and Stovner idrettslag, runs the ski tow and Liastua.

Infrastructure.

Within the district there are three sub-districts including housing, industrial estates and community services. Vestli lies in the north east, Stovner in the centre and the Haugenstua area is further towards the railway track and the district of Furuset. The district is well supplied with nursery schools and schools.

Stovner lies between two main trunk roads, Riksvei 4, Trondheimsveien and Riksvei 163, Østre Aker vei. Fossumveien (Fossum Road) is the main road through the district and cuts through the area joining up the two main trunk roads. NSB's (Norway's State Railway) main network forms a natural border between the districts of Stovner and Furuset. The railway from Haugenstua provides speedy transport in to the city centre from this area. Vestli and Stovner are linked to Oslo's metro system with stations lying in their centres.

The network of pedestrian and bicycle paths is well built out and provides short distances between most local destinations.

AIMS AND STRATEGIES IN THE DISTRICT'S PLANNING

The Strategic Plan for Stovner District.

The chief aim for the district is that "Stovner should be a safe and stable district – an attractive place to live in". This means:

- ?? A district with active organisations, an environment with varied leisure time and cultural activities.
- ?? A district with a well-developed structure of community services, offering services which are corresponding to the needs of the population.
- ?? A district in which a multi-ethnic community is looked upon as a resource.
- ?? A district which protects the environment.
- ?? A district where the public has influence on, and is actively engaged in, forming its own daily living conditions.

In addition to the above, a new element in the planning of period 2001-2005 contains approved working strategies which will affect all forms of services run by Stovner District. These strategies shall, wherever possible, be measurable and will form the basis for work involving planning and the production of services in the different service areas during this planning period. Sectoral strategic plans have been drawn up based on this.

The district's strategic plans have, since the first plan in 1993, been divided according to focal points of concentrated effort with defined main aims. The plans include departmental strategies

which are updated yearly, and are further adapted to the present needs. However, some of the strategies remain unchanged throughout the years, with only minor adjustments.

In the period of 1994-1997 the chief aim for target area 1V, Health Services was:
 “Availability, continuity and stability shall govern the health service in the district, where the patients are ensured to receive the necessary treatment and care, *and a systematic effort to prevent injury to health.*

Focal point of effort V, Protection of the Environment, had the following chief aim:
 To protect the district’s outdoor areas, attend to the district’s green areas and run attitude forming campaigns to avoid pollution and litter in nature. *Improve every day life for our inhabitants – physically and culturally, thus preventing health and social problems and give increased quality of life.*

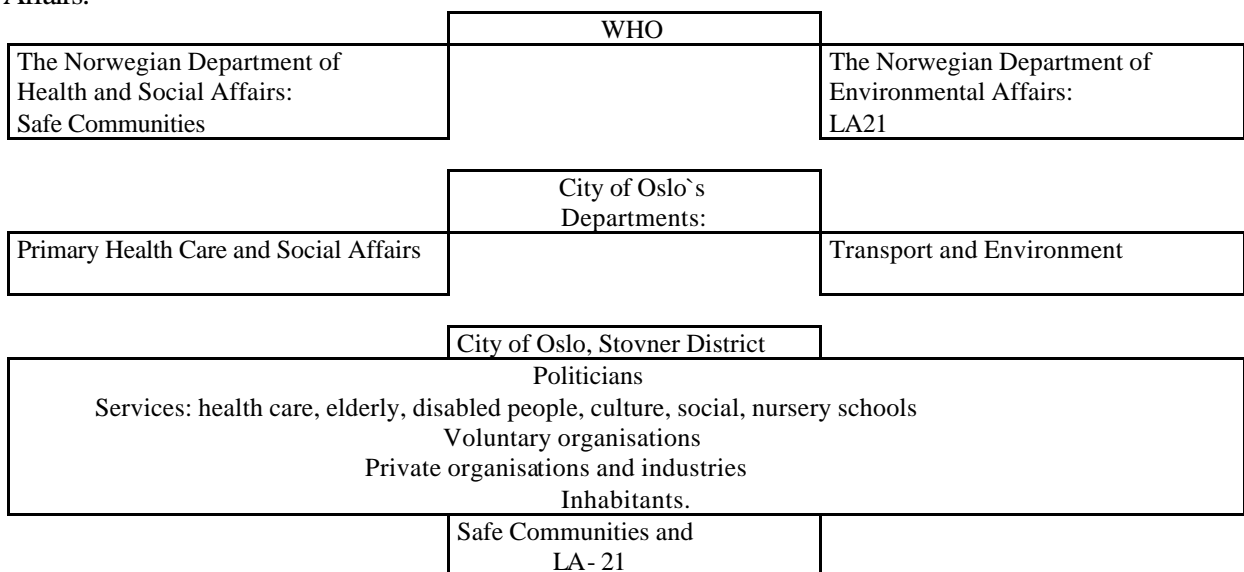
The Environmental Plan for Stovner District, Local Agenda 21.

The environment concept is defined as the actual environmental areas in the district of Stovner which we can and will have influence over. Based on this definition, the Local Agenda 21 describes four main areas:

- ?? nature and environment
- ?? environment and population
- ?? environmental health care protection
- ?? culture and environment

The district’s work with the local agenda will, roughly, start with the World Health Organisation’s (WHO) optimal vision of a community which safeguards health and environment in the best way possible. The following diagram outlines how we think the two international WHO-projects can be implemented in the local context. In the local framework, we must place central organs in the diagram before the local, municipal and voluntary apparatus.

We conclude with the two projects which have an influence on us all and which can be combined to one, whether this originates from the Department of Health and Social Affairs, or the Department for Environmental Affairs, from the City of Oslo’s Department of Primary Health Care and Social Affairs or the City of Oslo’s Department of Transport and Environmental Affairs:



Health Plan.

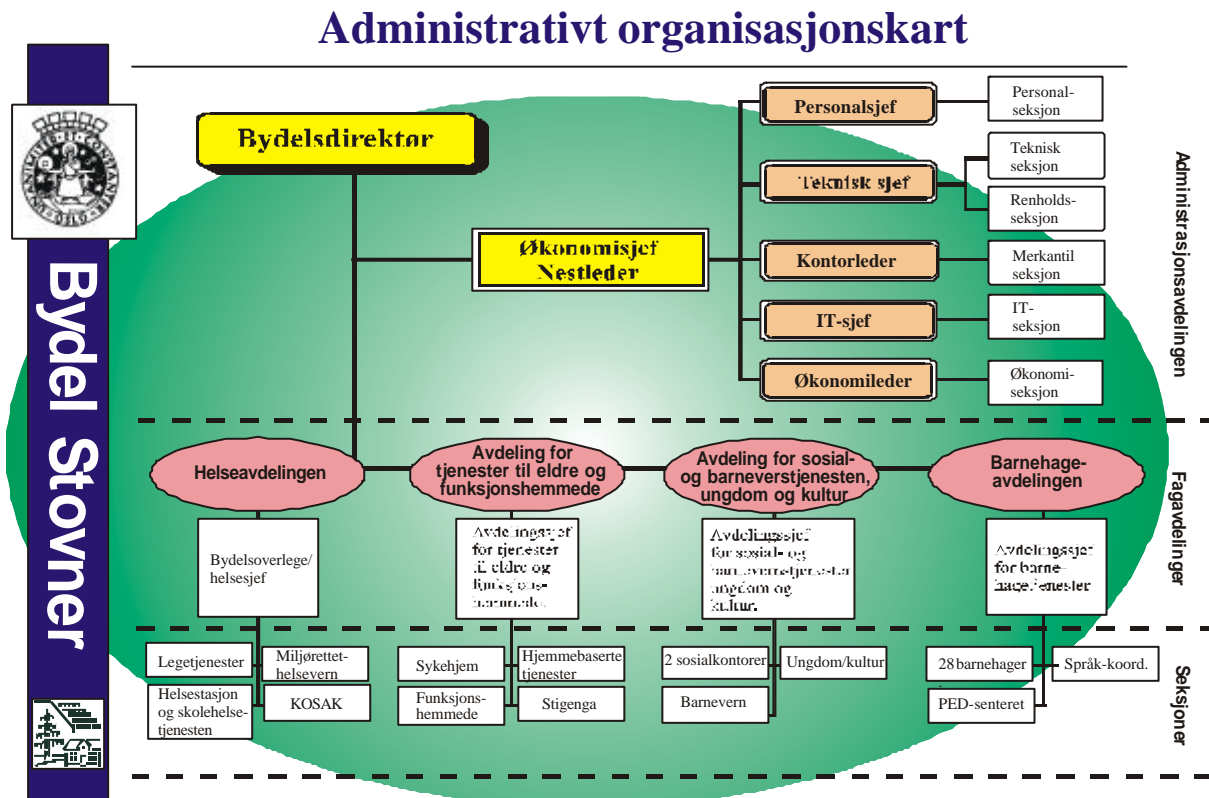
Since 1993, the health services in Stovner District have systematically worked towards establishing a thorough and functional plan- and reporting structure as basic conditions for developing optimal health services for the inhabitants of the district.

We have drawn up descriptions, aims, strategies and descriptions of activities for the central target groups of our services.

In January each year, as a direct consequence of the budget passed by the District Council, the district submits a joint presentation for the coming year.

This, plus other plans from the health services will have the following chief aim:

- ?? characteristic features of the central target group for the service
- ?? organisation and budget framework for the health service in the district
- ?? description of how the service is carried out today
- ?? aims and strategies for the service
- ?? activity plans for each particular section.



DOCUMENTED APPLICATION FROM STOVNER DISTRICT, OSLO, FOR THE STATUS OF “SAFE COMMUNITY”

1. Formation of a cross sectoral group which is responsible for injury Prevention.

Stovner District started its injury and accident prevention work in 1989-90 by concentrating efforts to prevent falls and injuries encountered by elderly people living on their own homes.

Work within the field of injury and accident prevention was increased in 1993 to include the entire district as a geographical target area and the whole population within it as the target group.

One-Year Project

The work was organised as a one-year project. The Chief District Health Officer took over the organisation responsibility since accidents are, according to the local government health legislation, considered to be a problem within hygiene (ref. preliminary work for § 4a, concerning environmental health care).

The leaders of the nursing and care services (who also organise the “handy man” services), the manager of the nursing homes, the manager of the home care services (who organises the home nursing and the home-help services), the leaders of the physiotherapy and occupational therapy services and the technical manager (who organises the caretaker service) joined the Chief District Medical Officer in the project team. The health consultant co-ordinated the project. (Refer to the administrative organisation chart on the previous page.)

Contact was established with the other public authorities and services for co-operation where relevant for injury preventive work. It transpired that the most suitable working partners were the transport authorities and the district hospital.

The project team formed working groups within the various service areas for the purpose of drawing up registration forms for falls and accidents, suitable for each particular location. The idea was that self - production generates a feeling of ownership, which is more binding as regards use and reporting. During the year in which the project lasted, there were regular meetings of the project team, with monitoring and analysing of the registered data, and further developing the registration forms, based on the use and reports from the working groups and service locations.

The work was evaluated after the project year was ended . Findings were then included in the normal routines and the project team was disbanded.

A project report was compiled for the year in which the project existed, 1993 – 1994.

Injury Preventive Work from 1994.

The health consultant was given the overall responsibility for work with injury prevention. The practical work with injury prevention in the district continued as a part of the regular services offered. The health consultant was the co-ordinator and followed up the work in other departments. The health consultant also continued to co-operate with other authorities. The injury preventive work demanded adjustments to external changes when, for example, the community’s services were opened for tenders from private firms. An example of this can be studied in the city’s road works (Oslo vei), which had the total responsibility for the city’s road

maintenance including the pedestrian and bicycle pathway system. At the end of the 90's the maintenance work was open for private offers and the good co-operation which we had, dissolved. We now have less contact with the firms responsible for this work.

Central Injury Register.

In 1994 – 99 a special telephone number, “Accident Phone”, was established for alerting when there were accidents/accident prone areas in the district. The public or employees could take contact when a need arose for sanding or snow clearance of roads or if there were any other reasons which caused the roads or pavements to be unsafe. The health consultant would then either pass on the message to the correct department or take direct contact with the district's technical services which could give help quickly in the form of e.g. sanding pavements outside sheltered housing, or possibly apply for a banister or extra lighting to be set up at vulnerable points in the pedestrian walkway system. The telephone had an answering machine which was on at all times outside office hours so that the enquiry would be heard on the following day. This telephone line was basically used in the cold season of the year and therefore linked to the climatic conditions which made being a pedestrian more difficult. The health consultant forwarded the message so that the area could be made “safe” again by snow clearance or sanding etc.

This special telephone service was closed down in the summer of 1999, when the district began to use a central switchboard and all numbers were given their own “post box” so that telephone lines could be laid in directly to the individual employee at the district's health department or technical authorities.

When looking at the current organisation chart, the “red circles” show how the different services offered in the district are organised. Services co-operate closely.

Since 1997, the City of Oslo has worked to establish a Central Injury Register. Stovner has been one of three districts where this has been tried out and it is also represented in the project team (ref. pt. 9). This has brought about some adjustments in the local injury prevention work, but since the health consultant still has the co-ordinating responsibility both on the local plan and as a member of the managing group at the central injury register project, continuity in the work has been ensured. In this way it is possible to ensure registration and the follow-up of local injury data, while certain registration areas have gradually been transferred to the central register.

2. Involvement of the local community network.

The district has long experience in work within a network which involves joint effort in a general area such as injury prevention, or around the individual so that joint, co-ordinated help can be offered in the form of preventive remedial measures. The following is an example of a network in the district of Stovner:

?? The health promotion project team

?? The Red Cross

?? The contact organ between various sports activities and Stovner District.

The health promotion project team is a joint effort organ, consisting of the following voluntary organisations:

Høybråten and Stovner Sports Club, Red Cross, Norwegian women's volunteer organisation for non-professional health care services (Norske kvinners sanitetsforening), The Senior Citizens`

Community Centre (Stovner Eldresenter A\L), The centre co-ordinating voluntary help between citizens (Frivillighetssentralen), The municipal organs represented by the section for youth and culture, KOSAK centre (physiotherapists, occupational therapists and psychiatric nurses), Home care services.

The health promotion project team has arranged several open meetings on fall prevention work.

?? Stovner Eldresenter AL

Stovner Eldresenter AL “The good food centre and meeting place for all over 65 years”.

Here we have arranged several information meetings on fall prevention.

?? Frivillighetssentralen – voluntary help between citizens

?? Pensioners` organisations

?? Parishioners` organisations

?? Velforeninger (local neighbourhood groups)

?? Job training projects such as the “Mugwort project”

An example from the above list in relation to the network which is offered with a view to contributing to good health in the district, rather than being defined as injury preventive. The “Mugwort project” involves removing this weed from areas which are not included in the different authorities` normal maintenance areas. This weed gives people prone to asthma and other allergic reactions, problems in the pollen season.

?? The Activity Clubs and the Rock (Music)Club

Oslo Youth`s Motor Centre, Stovner Rock Factory, the Video Work Shop or the other activity clubs for children and youths are important builders of networks, both as valuable leisure time activities for youths as well as an educational activity in collaboration with the schools.

?? BUKO (co-ordinating work for children and youths)

?? Types of Network

The purpose of working in networks as a method, is to give children, youths and their families a better offer of help and problem solving. The various types of networks report to BUKO (work for children and youths in Stovner District, co-ordinating group), which is the various networks` contact with the management of the district. BUKO consists of the heads of the various departments or their chosen substitutes.

?? School Health Care Service

The public health nurse service has been most successful in preventive work with youths, by establishing a health clinic for teenagers. During the last year this has also included a special day for boys only.

3. The programme will address all ages, surroundings and situations.

State Guide Lines.

In proposition 40, 1986 – 87, from the larger division of the Norwegian parliament, concerning environmentally linked health care, the health service was given particular responsibility for the prevention of accidents in the home, schools and in leisure time. This includes surveillance, registering, co-ordination of preventive work and individual measures in concrete cases. In the decisions on environmentally linked health care as in the Local Government Health Care Act, situations liable to result in injury are considered a “hygienic drawback”. This responsibility was

specified and followed up in Parliamentary report 41, 1987 – 88, “Health Politics up to year 2000. National Health Plan”.

Injury Prevention and Legislation.

When considering legislation, we must return to the preliminary work in connection with the Local Government Health Care Act (KHL), where injuries are defined as hygienic drawbacks. Based on this, the handling of cases in which injury prevention has relevance, is included in case work, directly or indirectly, according to the Local Government Health Act § 4 on environmental health care, §1-4 on planning, information and co-ordinating, or § 3-4 on medical and professional advising.

In addition to KHL with its regulations, separate regulations are drawn up in several areas with authorisation in other legislation.

Requirements to safety for children and youths, is provided (ref.§14) through regulations concerning environmental health care in nursery schools and schools etc. (1.12.1995, authorised by the Local Government Health Care Act), Requirements to safety for playground apparatus (19.07.1996, Product and electricity surveillance / authorised by the production control act).

The districts administrate the health acts and handle the planning/ building cases, according to the co-ordination agreement of 14.05.96. The district of Stovner is active in this area. Thorough handling at the planning stage can have great preventive effects and cost less than any later remedial/ reparation steps, which may arise. An example of preventive effort is a statement issued in the handling of a building application, which would prevent a petrol pump being put up in a parking area/walkway, which would be a threat to the safety of pedestrians and cyclists. In 1.9.99 the Planning and Building Authorities altered the decision concerning the placing of a petrol pump, based on this particular objection and the pump was placed in a position where pedestrians were less vulnerable to danger.

The handling of enquiries is mentioned in another part of this application, but nevertheless we choose to touch on a few examples at this point. Enquiries, which come because of slippery bridges or walkways, are followed up so that those responsible for winter maintenance or the technical authority/caretaker service in the district solves the problem. Normally it is elderly people who contact us, or it may be the home care services that ring for their clients. The technical authorities handle the case directly in the case of the walkways, or they forward it to the Road and Transport Authority if this is considered the correct “address”.

In 1999 a job-training project was also established. The project was called the “Mugwort project”, because one of the activities was to remove weeds causing allergy alongside the walkways. Anyway they are doing several activities and they have decided to change the name of the project to avoid misunderstandings. The project also handled other maintenance tasks in hand which are not covered by the other public services, for example to prevent safety of pedestrians and cyclists through cutting away bushes near the walkways.

The leader for this work in 1999 also used a map to draw in pathways in the district, which were in need of maintenance because of many holes. This ensured speedy improvement from the authority responsible.

This is a programme which will continue over several years, where both clients and the district`s interests will be taken care of. The district in this case will include the social services as well as the section for youth and culture, the health service and the technical authority.

In the schools and nursery schools the health service uses its own regulations directly (ref. KHL § 4a and regulations for environmental health care in schools and nursery schools) to safeguard children. Ref. §14, which also states that *the work is to be planned and run in such a way that accidents and injuries are prevented*. It also indicates that the regulations give the right of internal control, which imposes responsibility on the leader for securing that the regulations are followed. Regular, planned inspections are held according to legislation.

In cases where it is relevant to enforce the law to safeguard children's health as regards injury prevention or health care regulations, there are also other relevant laws/regulations that can be used in connection with individual cases. Through sanctioning and inspection work in nursery schools etc., it has become necessary to impose various changes to ensure safety and prevent accidents as regards the actual building or play apparatus.

Due to inspection or enquiries, private owners (housing co-operations/ co-owners) have had to improve the condition of their play areas to prevent accidents and meet the demands of the regulations. The Park and Sports Authorities (municipal services, now called Recreation and Leisure Service after fusion with the forestry authorities) have mapped out which play areas are to be upgraded, re-built, or removed, due to dangerous apparatus.

Injury Prevention and Planning Work.

Both the district's primal/strategic plan and the district's health authorities' plan, have injury prevention work as one of several main areas to concentrate their efforts on. The injury preventive work in Stovner District is well integrated in the daily running of the district's services, and with our collaborators. More recent legislation and regulations put demands on, and hold leaders for the services /personnel more responsible in different ways.

Injury Prevention Work and Close Collaborators.

Regulations formed by diverse central authorities outline the terms for following up children and youths. At the local level the municipal authority's responsibility is followed up through a close and partly informal collaboration, whether the appropriate organ is the District's health department, nursery school department, the department for the elderly and disabled, the district's technical section or the department for social and child welfare services, youth and culture. The district collaborates with partners from outside the district such as the Education Authorities, which are not de-centralised services, as well as the Public Health Authority (which has responsibility for the entire city's environmental health care) and the district's resource department.

4. The programme will address the concerns of the high-risk groups (such as children and the elderly), high-risk environments and aims to ensure equity for vulnerable groups.

The district has considered the elderly, as well as children and youths, as its focal point of attention for prevention work. Preventive work takes place within the local government services and via ideal organisations and voluntary work. The high-risk groups as regards accidents, are the elderly, children and youths.

The proportion of elderly in the district is increasing, especially the "old elderly". There is also a large number of children who were born in the 90s. About 25% of the district's population has an ethnic background other than Norwegian.

The Elderly.

The elderly are more prone to accidents than the young. *Through our injury prevention activities, we have focused especially on the elderly in nursing homes and also those living in their own homes, but with a need for help. However, we are also concerned with the elderly group, in general.*

In 1990 an occupational therapist and a doctor started a one- year scheme to prevent the elderly from falling in their own homes, especially the group which received home-help and/or home nursing. The home-helpers received 12 hours training on the situations which give rise to the elderly's tendency to fall (changes due to age, nutrition, illness, use of medication and physical reasons in or outside the house). Together with the home- helpers, a form was drawn up which they could fill in each time a client had fallen. The cause of the fall is registered in the form as well as any eventual dangers for future falls, which could be rectified. The "fall form" has now become an integrated part in the daily running of the home- help service.

The home-helpers have been given further training about once a year, often on the basis of the findings from completed "fall forms". The most recent follow- up took place in December 1999/January 2000. In the course of 1990/91 an occupational therapist and a doctor visited different groupings of elderly, informing a total of 700 people about falls and fall prevention. Later, there has been information in different interest groups, by invitation.

In connection with the injury prevention work being increased in 1993 to include different target groups, all falls which took place in Stovner Nursing Home, were registered. Each fall was followed up with the necessary steps. Educating and training of staff was based on concrete cases of falls.

The nursing home compiled its own internal programme for injury prevention to be used by the staff. This programme included diet, activity, lifting/moving techniques and illness in the elderly years.

In 1993 an information brochure on fall prevention was compiled. This was distributed to all those over 67 in the district, together with an invitation to a party for the elderly with accident prevention as a theme. The success was repeated in 1996. The brochure has been in use at the 70- year's medical check-up run by the health centres, since 1993. The oncoming years will give rise to great changes in how the health services are organised. This year has seen the establishing of a central monitoring of the population's general health in Oslo. This consists of selected age groups which have been invited to take part in health examinations which will be followed up at regular yearly intervals. This will have an influence on the local offer of a 70- year's medical check-up and the future organisation of it.

Since 1991, local pensioners from different housing areas and sheltered housing have had the opportunity of taking part in exercise groups in the district. The District's Department of Health has had the responsibility of training and following up the voluntary trainers who do this without any recompense. The social and activity- creating aspects are undoubtedly just as important as the injury preventive effort, or the training. The district's health department is involved with these groups by giving talks on diet, the importance of exercise and fall prevention. There is also a walking group run on a voluntary basis.

Focus on injury prevention and information has also caused the district's inhabitants to take contact via the "accident phone" when accident-prone conditions arise on roads, walkways or because of insufficient lighting. Other reasons for contact can be poor snow clearance or slippery conditions /the need for sanding. The telephone number is written on the back of the information brochure previously mentioned, while others have taken contact via the health consultant or the technical authority. The district has then complied by channelling the enquiry to the correct service, which can correct the situation.

Children and Youths.

Effort is concentrated on children in nursery schools and schools because they are less able to take care of themselves or judge the particular situation they find themselves in. Their safety is improved through necessary adjustments to their surroundings and by training.

Through various activities such as sports and culture, children can be provided with a safer environment which can have spin- off effects in many areas. In particular we can mention accident and violence preventive effects.

The district's services offer injury preventive work in nursery schools directly, while schools and the day care facilities for school children (SFO) take part only as co-operating partners since they are under the jurisdiction of another central authority. (School administration is not a de-centralised service in Oslo.)

Children and Youths are perhaps followed more closely than many other groups because of the previously mentioned new regulations, ref. pt.3. The district's health department has a permanent yearly inspection (in schools with leisure time activities(SFO) and nursery schools) according to health care legislation, either through the health consultant, the public health nurse service, or a combination of these. Safety is a natural part of the inspection. The preventive work is taken care of naturally in the work of the child health clinics during the regular check- ups of small children and the information given to parents and older children. Brochures suitable for each individual age group are distributed during the regular check- ups offered by the child health clinics.

Local co-operating partners are the individual nursery schools or schools which the district has the overall responsibility for according to health care legislation, to follow up and encourage, give advice or demand measures to be taken to prevent or avoid accidents happening.

The district's nursery school department has its own project where they have monitored the outside areas of the nursery schools and have come a long way in making the necessary improvements to ensure that all apparatus meets the requirements to safety. This ensures that all children can have a safe outdoor environment, which satisfies the needs they have for their development and level of maturity. In a similar way, the schools have safeguarded the smallest children through the Education Authority's playground project which was a follow up from Reform – 97 (for basic schooling) and the need for adjustments to accommodate 6 year olds taking part in the regular schools for the first time.

The district's health department has followed up particularly in the cases of injury to nursery school children, through both the district's general programme for injury prevention and also through the project for the indoor environment and absence due to illness in nursery schools (1992 – 1996) in which injuries were one of the registration criteria. The latter project was stopped because of extensive changes in the nursery school which were caused by moving the 6

year old age group up to the regular school (Reform-97) and the introduction of direct financial help to home based parents of small children.** This resulted in an entire age group of children vanishing from the basis of registration. Improvement has been registered in the indoor environment and absence due to illness in these years (Action programme children and health – monitoring local development work in the city of Oslo, report from the Chief County Medical Officer 11.02.1999, p. 109 and 117).

*Reform-97 comprised a complete change in the structure of the basic school system. This resulted in school starting age being lowered from 7 to 6 years. The nursery schools lost their oldest age group.

**Direct financial help: graded state grant paid out to parents with children from the age of 1 to 3 years who either choose to care for their children themselves (or hire a helper), or choose a reduction in nursery school time, combined with part financial help.

Under the direction of the health promotion team, an activity trail is being developed in the surrounding forest at the local ski cabin, Liastua. The activity trail is to have “art” which can be used in play (not play apparatus) and provide challenges. General use of the trail will give the children training in balance and co-ordination. The project is a co-operation between municipal services and voluntary organisations.

A project which is in the starting phase, aims to discover special needs which children and youths have, who appear liable to develop dangerous behaviour, i.e. aggressive, violent and unmanageable children and youths, also particularly quiet children who are neither seen nor heard. These children and teenagers must be discovered at an early point in time so that they can receive the correct help at the best time, through suitable channels. This project is not directly injury preventive, but if one is successful in the intentions, it will undoubtedly have an influence on the local environment in the form of making it safer.

One of the aims here is to develop methods. The project leader, who is a public health nurse, envisages a cross sectional collaboration based on priority plans which involve experienced, specialised personnel with a high level of competence and experience from work in a network context, across professions.

The district's health department has also close connection with the district's section for youth and culture, where they emphasise the preventive aspect in the broadest meaning. This service is responsible for the running of the activity clubs for youngsters and the video workshop. Both doctors and public health nurses have been present at the clubs or taken part in panel discussions together with the youths at the video workshop, to give advice and provide this age group with knowledge on injuries, relationships between people, and prevention of infection. An example of the result of the latter is a video talk show on platform shoes and piercing. A similar video talk show is planned on the topic of sexual diseases.

5. The Programme should have a mechanism to document the frequency and causes of injury.

Choice of Indicators and Quality Safeguarding of Data.

When the action to prevent falls started in 1990, we selected breaks in the hip joint as an indicator for fall accidents because reasonably correct numbers can be acquired. Almost all breaks in the hip joint are hospitalised and the diagnosis is relatively reliable. All those admitted to hospitals with ICD-9 -diagnosis 820, were registered as hip joint breaks. Information on the admittance, diagnosis and address was acquired from the Oslo hospitals' data register.

We have chosen to continue to use the number of hip joint breaks as an indicator for fall injuries because this has been relatively easy to do. The health consultant has at all times had this responsibility and followed up the registration work.

When required, Aker hospital (the sector hospital) reports back yearly to the district authorities with information on the number of inhabitants who have been admitted with breaks in the hip joint. This form of co-operation makes it possible to control whether or not all of these particular breaks are actually registered. Some deviation will possibly arise, however, when our inhabitants are admitted to other hospitals outside “our” sector hospital. When the central injury register is in operation, it will be possible to include also those who we “lose” today.

The Registration of Falls.

The district’s health consultant also follows up the care and nursing services via the “fall forms”. The reverse page of these forms register information concerning which steps should be taken to improve the client’s flat or surroundings in the nursing home. This gives us ample possibilities for local preventive work, since the reports sent to the nursing home or the home care services include information which can be important for the daily running of things, routines which can be crucial for the prevention of falls and fall injuries. (The district’s health departments’s rapport: Fall/Fall Injuries 1999.) Copies of the forms from the home care services are sent to the health consultant. The work is valuable since the results of registration uncover unfortunate routines and possible traps liable to cause falls in both the nursing homes or in private homes. This may be of a physical nature, such as necessary rearranging of furniture or other items such as rugs, loose cables etc., or things which are influenced by the service offered, the staff situation or routines in the wards of the nursing home. One can also become aware of extra needs, e.g. for nursing rounds at the home when there is a remarkable number of falling accidents because of patients getting up during the night without help present. The employees in these services and the district’s handy-man service do a good job in connection with registration, adjustments or improvements.

Injuries in the Nursery Schools.

The registration work which took place in the district’s nursery schools in the years 1994 – 96 indicated that the frequency of injuries could be improved by changes in routines. An example of this is the remarkable number of injuries registered at a particular time of the day (12 o’clock). A closer inspection of the routines showed that at that time the children were in the process of going out after their lunch, there was a lot of activity and some children were outside while others were still indoors.

By focusing on this problem through information to the nursery school’s staff, the frequency of injuries was somewhat reduced and the time of injury was pushed forward – to when the children were on their way indoors again, two hours later. During the duration of the project, the district’s health department was regularly in contact with the nursery school service so that findings and results were passed on to nursery schools via their group meetings which their leaders held.

Similarly, the health service offers it’s competence to the individual nursery school or via group meetings about either injury prevention measures, other forms of information or health related requirements which can bear relevance to work within the nursery school service.

The aim is to reduce damage as much as possible. Children go through different phases in their development and maturing process. This means that through play they can be vulnerable to challenges they are not yet ready to tackle and which can result in injury.

Even though the purpose is to prevent injury, there must be space for the child to develop in a safe but also exciting environment, pitched at the child's age level (ref. to the activity trail at Liastua and nursery schools with safe and adequately maintained playground apparatus).

Registration period 1990 –1993

The elderly were the target group. Weight was laid on registration, information and education. The work is described in pt. 4.

Registration period 1993-1997

In addition to the registration work previously mentioned, in this period it was decided to register all injuries reported to the three health centres in the district.

The registration work gave a reasonably good picture of those places which were most frequently hit by accidents. The health centres received lesser injuries in normal working hours, whether they came from the nursery schools, schools, workplaces or from homes. The health centres compiled their own injury registration forms which were used in this period. The district is divided into three "regions" each of which has its own health centre which receives the injuries occurring in the nearby area, whether it is in people's homes, the nursery schools, schools, or industrial accidents. More serious injuries requiring e.g. X-rays or special treatment, go directly to the casualty clinic or the hospital, and are often followed up by the local health service.

Registration at the health centres lasted to the end of 1996, when it was considered one had a fairly good overview of "who, what and where".

The Central Injury Register.

Work was started to set up a central injury register for the city of Oslo in 1997 and has been a state-supported project, with a project leader from the Clinic for Preventive Medicine at Ullevål hospital. The injury register was transferred to the Health Authorities at the turn of 1999-2000. Stovner is one of the 3 test districts (districts 14, 17 and 22) where the casualty clinic, schools, nursery schools, home care and nursing services all register falls and fall injuries. The health centres are the next due to take part in the registration work.

In addition to the home care services and the nursing home, nursery schools and schools in the district take part as registration units in the project for setting up a central injury register for Oslo. In the case of the nursery schools, the gathering of data is organised in the same way as for the nursing home and home care services, but recently a trial method was introduced in which the nursery school service receives the reverse side of the form so that they themselves can handle it and follow up "deviations" for the good of health, environment and safety in the nursery school. In the case of the schools, fall prevention has been the responsibility of the Education Authority which is a municipal service and here there have been more problems in obtaining reports when injuries and accidents occur. A few of the schools in the district have been successful in establishing a well-run system. The district's health department will attempt to ensure better reporting routines in the autumn, 2000, through the school's own health care service. Return messages/reports are distributed from the project to the participators, the district's health department, the nursery school authorities and the education authorities.

Injury Data.

After each year, the district has had access to the numbers of injuries recorded at Oslo's casualty clinic which is under the administration of Ullevål hospital and is a central part of the project for

setting up a central injury register. Within the last two years, the district has had a good 1000 inhabitants who have taken contact with the casualty clinic. Help is sought there, either because the local health centres are closed or the injury is so grave that special examination is required, e.g. X-ray. Routines for handling and assessing the numbers from the casualty clinic, as well as quality guarantees of findings, require more handling.

We believe that the way we work has given us methods which have made it possible to document injury frequency and the pattern of causes through our main efforts of monitoring and gathering data consisting of the numbers of injuries, injury mechanisms, gravity, accident frequency and accident risk – and that we have documentation to prove that the measures taken have effect.

Co-operation, both internally and externally, with other authorities, volunteers etc., has been important to this work. Another consequence of working together in this way is the spin-off effects which imply that a larger area of contact has been established. A better knowledge of each other's area of work has been gained and we have also developed other ways of co-operating.

Continuation of this Work

Knowledge and co-operation is important in work with target orientated preventive efforts. The Department's Handling Plan, 1997 - 2002, chap. 6, on accident prevention and experiences, laid weight on the following points:

- ?? number of injuries, grade of damage, accident frequency and accident risk
- ?? economical consequences
- ?? documentation that measures taken have effect
- ?? cost and useful effect
- ?? public's acceptance of such efforts
- ?? co-operation, internal (other services) and external (other authorities, volunteers etc.)

It is evident from the above that weight is also laid on calculation of economical consequences, costs, and how useful the effect is, in addition to how well accepted these efforts are by the public, in general.

In our work we have not registered data for all the points mentioned here. As regards the public's acceptance, we experience that co-operation with both the public and employees is good, and the fact that they initiate contact gives a form of acceptance of the work being done.

Detailed calculations with an economical overview of the cost compared to usefulness, has not been carried out in Stovner District. The actual cost of hip joint breaks can be calculated in various ways, dependant on whether one restores back to nearly the same level of function, becomes dependant on home care services, must be admitted to an institution, or dies. Treatment in hospitals will always be part of the cost as well as the need for training after the rehabilitation phase. We return to this in pt.7.

Avoiding hip joint breaks and sustaining optimal quality of life in the elderly years must be considered good public health. It is necessary to focus on - and set aside time for- this type of preventive work for the purpose of fulfilling the state's intentions, which can result in reduced hospitalisation and the savings which this entails.

6. The programme must be a long-term approach, not one of brief duration.

The injury prevention work is based in the Health Plan, and in later years linked up to include work with Agenda 21.

The Local Agenda 21 acts as an “umbrella” which includes the active groups found in communal and private/voluntary work in the district. The district mentions safe local communities in the district council’s (BU) case 124/98 on the Local Agenda 21, which has resulted in the environmental plan for the district, BU- case 37/2000, with a plan for future activities. Not only direct injury preventive work as it was organised in the 90s is included in this, but also a further involvement to seek safety through the local environment.

Through a political anchoring and via the district’s plans for the service network and voluntary efforts, we mean we can safeguard further efforts within preventive work where gains can be achieved in the form of a safer local environment.

The working plan for the district’s health department and the work done through registration, reports and following-up by the service areas involved, education on injury prevention as well as exchange of experiences, has shown that injury prevention work has been and is one of the areas which the department invests its main efforts. It has thus become a permanent part of the regular work in the services, in co-operation with internal and external services, authorities and others which have proved to be relevant working partners.

In our work and our plans, importance is laid on activity over a time span, i.e. the long-term aspect is what gives results and can be measured in the form of improved public health.

The nursery schools were given their own follow-up programme from 1993 when the indoor climate and absence due to illness was monitored over time. Absence due to illness was registered according to the most normal causes, in addition to the registration of absence due to injuries. (Refer to the previous description in pt. 4.)

As described earlier, since the first health plan appeared, injury prevention has been considered a main focal point of effort in accordance with signals from the central authorities e.g. Act of Parliament no. 37 (1992 – 93), on *Challenges in health promotion and prevention work*.

The purpose of describing work done in the past, is to show that already at an early date the district focussed on injury prevention and later continued to do so, both on the planning and on the practical side. This is similar to the way in which the central authorities have continued their work by their Handling Plan 1997-2002, on prevention of accidents in the home, at school and in leisure hours.

Please refer to pt.5 which not only describes the programme with methods used, but also mentions the long-term efforts which can give documentation of the results achieved. Refer also to the various service’s activity plans in which prevention rather than treatment is stressed at all levels.

In the case of the child health clinics, children with a high risk of injury are still the paramount focus of effort as is stated in the Handling Plan for year 2000: *Here is a substantial and very important challenge based on the fact that many children are daily admitted to hospital in this country because of injury or accidents and in Norway we still experience more fatal accidents involving children than in Sweden*

(which it is natural to compare us to). In addition to individual consultations, we carry out home visits and group consultations.

Injury and accident prevention work is continuously given a central position for future work in the plan for environmental health care.

7. The programme evaluation should include indicators which show effects and provide information on the process as it advances.

The aim throughout the 90s has been to reduce the number of accidents which lead to damage of health in the district of Stovner, by systematically carrying out injury preventive work. The strategy is:

1. Registration of accidents and accident mechanisms for the purpose of starting up effective rectifying measures.
2. Remedial actions which can be preventive.

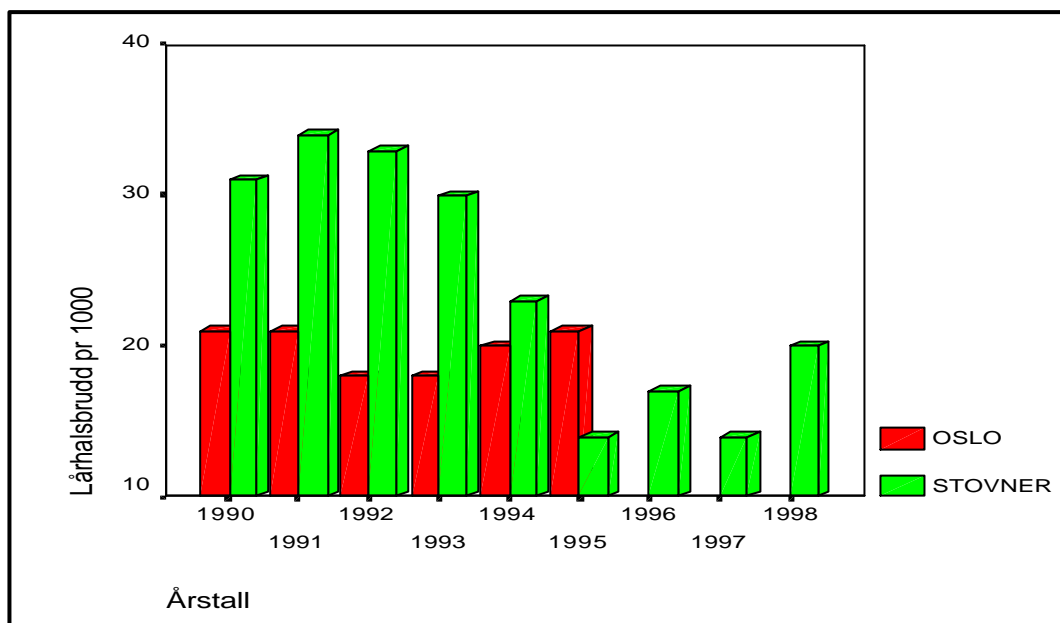
In order to document and evaluate, it is necessary to find indicators which can tell how successful one is in achieving the goals. Even though it is difficult to measure the effects, it is still important to continue with preventive work. It can be difficult to find a suitable indicator because "accident" is an unprecise term and accidents can have many consequences. It can be difficult to register patients who visit doctors in different places, and the threshold for when one visits the doctor varies considerably. Many factors influence people, not only our intervention, and we do not therefore always know the causes of changes which lead to improvement. Also, we have not had any "control group" which has not been exposed to our influence. The numbers which we have are small, which make the results unsure.

The district itself has not compiled an overview of the cost to the community in connection with the prevention of hip joint breaks. The Clinic for Preventive Medicine, Ullevål hospital, in conjunction with a seminar, worked out a simple cost overview to indicate which economical savings lay in "avoided" hip joint breaks, based on an article in the medical journal *Nor Lægeforen* 1998; 118: 37-9. (pt.11). They calculated that Stovner District had "saved" 85 hip joint breaks in the period of 1993-1996. This consists of a 50% reduction compared with the level in 1992. The district used approx. NOK 150,000 in preventive work during this period, while the anticipated cost of 85 hip joint breaks was stipulated to be a total of NOK13,000,000. From this total, the cost to the district in the form of care and nursing expenses was calculated to be approx. NOK 5,000,000.

The article in the medical journal is a form of evaluation of the injury preventive work with focus on hip joint breaks in the district of Stovner. It discusses prevention through remedial steps such as information to the elderly and employees working with care for the elderly, on the risks for falls and fall- traps in the home environment. The usefulness of the steps taken were evaluated by studying the registration of the number of hip joint breaks amongst inhabitants of the district compared to the rest of Oslo. The result showed a significant reduction tendency for the period, in comparison with the numbers registered in the remaining part of Oslo.

The article concluded, in short, with the following: *We believe that the preventive work can have contributed to reduction in the number of hip joint breaks, but that it is difficult to differentiate between the effects of the different steps taken. The value truly lies in a combination of the different activities and that they have become a part of the day to day work.*

We have access to the total number of hip joint breaks each year from the district's sector hospital, Aker sykehus.



Number of hip joint breaks per 1000 inhabitants over 67 years, 1990-1998

The above graph shows the number of hip joint breaks per 1000 inhabitants from 1990-1998. The decrease is clear from 1993/1994. Recently the numbers have been relatively stable. The numbers from 1999 show 16 hip joint breaks per 1000 in the district in the age group which was controlled, which indicates that the totals continue to lie on the same level. Accident registration in the district continues locally and in conjunction with the Public Health Authority.

8. Each community will analyse its organisations and their potential for participation in the programme.

The district's organisations have been analysed through the extensive and systematic work done with Local Agenda 21. Others not already mentioned in the district's LA 21- environmental plan, have the opportunity of joining, so that they may take part in local activities across the traditional channels of co-operation. The district's health department contributes to the planning and practical work, to ensure that accident prevention is focussed on all arenas, in the same way as the previously mentioned co-operating partners or potential partners through their field of work or area of activity.

We have described how the district systematically works preventively, through the different points in this application. This work is placed in the main planning and is carried out by each of the services' individual plans for activities. Co-operation on the formal plan is described, but the

work also takes place through informal channels and contacts within the community and the different organisations. The district's total number of inhabitants corresponds to a medium large Norwegian town, but geographically the area is restricted and the contact network is close.

The district's inhabitants are interested in issues which concern the local community and attendance is good when there is a discussion on changes which are of consequence to the local environment or threaten to reduce local quality of life. A good example of this is the common cause to avoid a main trunk road system being built straight through the green belt and the sports area. In addition to problems caused by noise and pollution, this would also give rise to an increased danger of accidents because of heavy through-traffic.

9. Participation of the health care community in both the registration of injury and the injury prevention programme is essential.

In previous chapters we have described the registration of falls and fall injuries (ref. pt. 1,4 and 5) amongst elderly people living at home or in the nursing home. Also, the registration of injuries at the child health clinic and in nursery schools as well as the use of the "accident phone" – a special telephone line where employees or the public could indicate places where accidents were likely to occur causing injuries.

In the starting-up phase, contact was also taken with other municipal authorities and services for the purpose of co-operation where relevant for accident prevention work. The most useful partners proved to be the road authorities and the sector hospital.

Since the start, the health consultant has had the co-ordinating responsibility and has received the registration forms from the various services, which are gradually reduced to data in coded form, (i.e. register falls, fall injuries and accidents), as the various services produced their forms specially designed to suit the individual area of registration. Finally, all this is put into use within the area intended. The follow-up takes place in the form taking contact with - and return messages to - the various service locations.

The health consultant has also followed the progress of the work through the first project team, now the co-ordination group, in the project for the central injury register in Oslo, in which the Chief District Medical Officer or his official substitute are present according to the requirements of the agenda for the meeting.

In addition to the registration work, weight has also been laid on training staff working in the home care services and of elderly people in groups, on the subjects of diet and activity/exercise groups. Dangers of falling at home were given priority, as well as individual risk factors experienced by the elderly and finally diet and activity.

It has also been mentioned that the district's health department takes an interest in the pensioners' exercise groups by providing training for the voluntary leaders and the pensioners are given information on fall prevention. The different services and the voluntary trainers are offered courses held by doctors, nurses, occupational therapists and physiotherapists. The home care services have also made use of a food card system which can also be considered part of the preventive work since malnutrition and insufficient vitamins/minerals are relatively common amongst the elderly. The nutrition project is at the moment the responsibility of the Health Care

Authorities. Poorly compiled meals can make the individual vulnerable to osteoporosis and break injuries. Focus on diet is therefore truly a preventive measure.

The information brochure "This year 50 elderly from Stovner will break their hip joint" has been distributed as part of the new arrangement which guarantees that a patient over 70 can choose a fixed doctor responsible for all their visits to the health centre. This family doctor can emphasise the importance of injury prevention – also in one's own home. Free consultations - the 70-year check-up - were started in the middle of the 90s.

Continuation Work

Under previous titles, information is given on the current work (from 1997) with establishing the central injury register for the City of Oslo. Stovner District has been one of 3 trial districts*, with a representative from the district's health department in the project team. When the project was later transferred to the City of Oslo's Public Health Authority, which was delegated the responsibility for the municipal environmental health care from the beginning of 2000, a co-ordinating group was set up to secure continuity of the work. The district is still represented by one member in the group. Registration of falls and fall injuries has gradually been transferred from the district to the central injury register for Oslo.

On the local plan, the district follows-up with nursing and care services, through page 2 of the injury registration form (described in greater detail in the district's health department's rapport "Falls/ Fall Injuries, 1999).

*The other districts are Helsefyr-Sinsen and Sogn

The local work with injury prevention in the district continues as a part of the fixed services we have to offer, but with continuous adjustments due to external changes. One result of establishing the central injury register is also that a part of the registration which was previously the district's responsibility, now goes to the central register and the reports which we receive, come therefore as forwarded messages from our co-operating partners there.

The district has kept a form of parallel registration, covering the information sent to the central injury register, i.e. the fall form is sent through the district's health department. This is the case for elderly living their own homes using the home care services and elderly living in an institution. We experience that the local need for registration is not identical to the central needs. The difference lies in the central need for statistics, whereas we also have the need of reporting back to the specific location at the nursing home in the case of e.g. alteration to routines or the staff situation, which are a direct result of the registration findings or messages from home-helps concerning the need for improving a client's flat.

This requires close co-operation with the district's nursing and care services, which are located in the district's department for elderly and disabled and with the region's sector hospital where the IT departments provide us with the (quality guaranteed) numbers of the district's inhabitants admitted to the hospital, to our "indicator diagnosis" i.e. ICD 10-diagnosis for hip joint breaks. Oslo's casualty clinic offers similar reports of injuries registered in the ICPC-diagnosis system.

10. Be prepared to involve all levels of the community in solving the injury problem.

In accordance with the final document from the conference *Agenda 21*, The UN-conference for environment and development in Rio, Brasil, 1992, the district should continue to work in

dialogue with the inhabitants, local organisations and businesses to secure a prosperous development of the local community.

By the mandate provided by the Local Agenda –21, Environmental Plan for Stovner District, Stovner District Council 23.03.2000, the authorities have bound themselves to continue preventive work in four main areas (ref. page 6 in this application). The figure on page 7 indicates how one envisages the different elements woven into each other.

The district`s planning authorities lay weight on long-term work and continuity to gain results. The district`s health department, through the implementing of the regulations governing individual cases, will strive to secure knowledge on health-promoting measures and accident prevention.

A common investment can take place through the health promotion project team (described on page 10), the public services and voluntary organisations or private businesses. The public services supply the competence and resources, while the organisations can provide unpaid work for the common interest and the running of things.

The network team, as well as the child and youth co-ordination group (BUKO, ref. Pt. 2) works actively within injury prevention. In its planning phase, the project can have a preventive effect by catching up with children and youths in the risk zone for bullying, violence and drugs/alcohol abuse. Work across different areas of interest in these projects is just as important as the contact out to and with, the local community.

The public can avoid walking on roads with heavy traffic, due to a good system of paths for cyclists, pavements and walkways as well as nature trails. Even the road system lies on the outskirts of the built-up areas and each residential unit is frequently built around a central “green core” with a playground lying in it and a nursery school in close proximity. Using the road can be considered “the long way round”, which is definitely a preventive factor.

The work carried out in the section for culture and youth is very closely linked to voluntary work and the sports organisations and through this it forms a link to the district`s inhabitants, in many ways.

The district`s health service has injury prevention as their focal point of effort and attempts, through the different services, to continue focusing on this area while gathering the necessary data and co-ordinating the work for the future. The doctors and occupational therapists have repeatedly arranged information meetings at Stovner senior citizens` community centre (Stovner Eldresenter A/L), the three sheltered housing complexes, in the groups linked to the churches, in the pensioners` clubs and in the pensioners` exercise groups. We invited ourselves to the first meeting, then after that we were invited. At the meetings we give general information on prevention of injuries, as well as demonstrate different types of equipment, which would improve safety.

11. Disseminate information on the experience, both nationally and internationally

The district`s health department has contributed with an exchange of experiences through enquiries on the telephone from other districts, distribution of suitable material and by hosting visits or visiting other districts which are considering starting up work or projects within injury

prevention. The staff of the district's health services also contribute with information or exchange of experiences at varying courses and seminars, such as the following:

- ?? Article: Steihaug S, Nafstad P, Vikse R, Beier RM, Tangen T : Prevention of hip joint breaks in Oslo, Stovner District. Medical Journal Nor Lægeforen, no.1, 1998; 118:37-9.
- ?? A talk on accident prevention work in the district and the results at the Sundvoll seminar 10.12.94.
- ?? In 1993 a talk was given on the district's abortion prevention work (SOS young girls) at the John Hopkins School of Hygiene and Public Health.
- ?? A stand at "The Good Life" conference in Oslo, 29th and 30th January, 1998 (Oslo Plaza).
- ?? A talk on prevention of hip joint breaks in Stovner, at the Sundvoll seminar in January, 1998.
- ?? A talk on the theme day on Safe Communities arranged by the county doctors in Oslo and Akershus, 13th May, 1998 (Oslo Concert House).
- ?? A talk at the meeting about local injury registration, arranged by the Department for Health and Social Affairs and the Clinic for Preventive Medicine, Ullevål hospital - Project central injury register in Oslo, 29.09.1998 (Government Buildings).
- ?? A talk on injury prevention work in the district at "Primary Medicine Week 1998".
- ?? A talk on injury prevention work in the district at the Norwegian Society for General Medicine (NSAM) 1998.
- ?? Taken part in "There is a use for everyone" in Drammen, and contributed with the district's experiences under the "junction" on Safe Local Communities, on the 29th and 30th November, 1999 (First Hotel Abassadeur).

Visited and held talks on accident prevention and the district's results in this area:

- ?? 27.09.1994 Sogn District
- ?? 26.03.1998 Rakkestad municipality
- ?? 29.10.1998 Oppegård municipality
- ?? October 1998: Safe Local communities in North-Trøndelag
- ?? 17.03.1999, District of Sagene-Torshov
- ?? Frogner health centre, district of Bygdøy-Frogner
- ?? 27.10.2000 Romsås District, in connection with Swedish Folkehelse's guests from Gothenburg .

We have received visits and held talks on injury prevention and the district's results in this area, in the following:

- ?? 10.11.1994 Commissioners for environment and transport and commissioner for culture and education
- ?? Health administrators from Great Britain visited the district, autumn 1994, and talks were given on several subjects, including injury prevention work in the district and the results
- ?? A group studying health administration at the university in Oslo (UiO) visited the district 01.11.1995.
- ?? 19.12.1996 the district received a group of doctors/students/leaders from the co-operation of UiO/Moscow medical faculty and academy of science. There were several talks, including one on accident prevention work and results, in our district.
- ?? In June 1996 the Chief District Medical Officer held a lecture at the faculty in Moscow.
- ?? 05.06.1998 The Osteoporosis project, Innherred hospital
- ?? 21.04.1999 representatives from the health services in Kongsvinger community
- ?? 2.10.1999 representatives from the child health clinic in Larvik community

In addition, for several years the district's health department has held lectures on the theme of environmental health care and accident prevention work for students at the nursing college, Oslo and also for those who have their practice in Stovner District.

?? 13th – 15th May 1998 Taken part in “The Seventh International Conference on Safe Communities “, Rotterdam, The Netherlands.

12. Be willing to contribute to the overall network of “Safe Communities”

The district believes that by offering our competence and experience to others, as we have done and intend to continue with (ref. pt. 11), we will be able to strengthen the combined network of Safe Communities.

As far as our economical situation will allow, we will take part in national and international conferences.

In this present year, a representative from our district has taken part in the “6th World Congress on Environmental Health” which was held in Oslo from the 5th – 9th June. The congress aimed to concentrate heavily on the topics of environment and health, in which accident prevention work and Safe Communities had their parallel session.

In September 2000 the district's health department received a fairly large delegation from Udevalla, Sweden, which comprised of doctors, nurses, therapists and midwives. They wished to learn how this district organises preventive work and environmental health care. Concentrated effort within accident prevention work was a relevant topic in connection with this visit.

AN EXAMPLE FROM REPORTS AND TABLES FOR ACCIDENT PREVENTION WORK IN STOVNER DISTRICT

Stovner nursing home – summary 1999

Stovner nursing home has a capacity of 181 patients as of 31.12.99. Ward 4 N is a section for patients suffering from senile dementia and has 24 places in a secluded unit. The nursing home has a day centre and offers periods of short- term residence.

In the course of 1999, a total of 286 falls/fall injuries were registered at the nursing home.

Where do these falls occur? About half (151) are falls in the patient`s own room in addition to 25 in the patient`s toilet. 45 fall in the corridor while they are moving, 32 in the dining room and 20 in the lounge. The remainder fall in various other places.

144 of those who fall do so in connection with walking, with or without aid (crutches etc.). 18 fall or slide from a wheelchair, 40 fall or slide out of the chair they are sitting in, 7 fall and slide from the WC and 46 patients fall out of their beds. The remaining falls occur in different situations and only one stumbled over a rug.

A large number of patients fall between 3pm and 5pm, i.e. 101 patients –or a good 30%- of all falls are registered in this space of time. During the night there is a higher rate of falls in the period between 1am and 5am. In the latter period, the patients have attempted to go to the toilet alone.

The table shows the distribution of more serious falls:

Ward	Total falls	Women	Men	External treatment:			
				hospitalised	Fr.col.fem.	No.breaks/ treatment.	Neg, x-ray
2n**	31	12	19	2	2	0	1
2s	38	31	7	0	0	1	1
3n	64	57	7	1	1	0	1
3s	35	18	17	1	1	1	3
4n	56	47	9	0	0	0	0
4s	55	40	15	0	0	0	0
Ward unknown	7						
Sex unknown	(7*)						
Total	286	205*	74*	4	4	2	6

**data missing for 3 months in 1999

2. Injuries and Treatment of Injuries.

2.1 Supervised by doctor.

A total of 18 patients required attention from the doctor after a fall. These visits showed that 2 of the 18 cases did not require treatment, while 6 cases were suspected breaks and sent for x-rays, in addition to the 5 which were actually treated for break injuries. A total of 10 patients were sent to hospital to determine if they had sustained break injuries, 4 were hospitalised due to fr.colli femoris and 1 had a broken rib.

The remaining treatments more than the normal doctor`s visit, resulted in 1 external wound sewn and treatment for soars.

2.2. *Other injuries and treatment of them*

193 patients from the total of 286 who fell, were registered without injuries. In previous paragraphs, 10 of the fall injuries have been suspected to be possible break injuries or breaks and sent on for further examination, possibly treatment at the casualty clinic, or in the hospital.

Injuries which were treated in the various wards by the staff present.

Type of injury	Number
Pain conditions, different parts of body	28
Grazing and small scratches	19
Small cuts	15
Head/trauma	11
Others	20

3. Training of staff

3.1. *Internal training*

The nursing home has previously compiled a brochure for internal training. The following topics are included:

Prevention:

- . The state of diet and nutrition
- . Why do the elderly fall (normal changes due to age and changes due to illness)?
- . Remember effects of alcohol and medicine as a cause of falls
- . Reasons for limited activity in the elderly and movement techniques
- . Danger signals when the elderly are carrying out physical activities

The health consultant, together with the project leader for the central injury register, has had information meetings in connection with the new forms and filling them out.

3.2. *Brochure*

An internal brochure for the prevention of fall accidents has also been compiled for the use of the staff, patients and relations. This brochure is printed in blue to differentiate it from other internal documents.

3.3. *Other Measures*

The nursing home received financial help in 1999 from the injury register's funds for buying the "Safe Hip", also called hockey pants, for their patients.

EXAMPLES OF TABLES FROM PREVIOUS REPORTS FROM THE NURSING HOME

CONSEQUENCIES OF FALLS	1994	1995	1996
Fall without injury	222	217	207
Total falls with injury/trauma	105	79	86
Doctor's visit	33	31	22
Sum total of falls	327	296	293

It is also evident that the conditions in 1995-1996 are relatively similar. However, one can measure a marked difference since fewer were in need of a doctor's help, the number of hip joint breaks were halved and that apart from other types of break injuries, the injuries were on the whole minimal.

1st half year	1994	1995	1996
Number of injuries	65	39	35
Hip joint breaks	6	4	1
Other breaks	5	1	2
Doctor`s visit	23	15	7

2nd half year	1994	1995	1996
Number of injuries	40	40	51
Hip joint breaks	3	4	3
Other breaks	3	1	5
Doctor`s visit	10	16	13

INJURED WHO HAVE A HOME ADDRESS IN STOVNER DISTRICT, REGISTERED AT OSLO`S CASUALTY CLINIC IN 1999.

The casualty clinic in Storgata, Oslo, started registration work at an early point in connection with the project "Central Injury Register". The districts which take part in the project have access to the injury data which is relevant to their district.

Data material

In the spring of 1999, the district`s health department issued an enquiry to the services to find out if there was special data which could be of interest from a preventive aspect, so that this could be acquired. No return message was received.

The district`s health department has therefore decided to fetch information concerning the number of those admitted to hospital with hip joint breaks, since this data has until now been used as the district`s indicator in injury prevention work. In consideration of the injured person, an obvious case of breakage will be driven directly to the sector hospital, but the formal admittance to the hospital will still be registered at the casualty clinic. General information is also acquired on the number of injuries diagnosed, the date of injury, the point in time, where the injury took place, status at the time of injury and the injured person`s activity. Data of a personal character is not registered.

In the event of the casualty clinic`s data system being out of order, there is no simple manual material for this purpose. There has also been discussion on a suitable routine for gaining access to this material, at which periods, and what needs the districts have.

Number of injuries

In 1998 there were 1039 people from Stovner District who took contact directly with the casualty clinic in connection with personal injuries.

In 1998 the number is similar i.e.:

- . In the period of 1.1.99-30.4.99, 372 injuries were registered
- . In the period of 1.7.99-31.12.99, 427 injuries were registered
- . Injury data for the period May and June-August 99 is recorded, but this period partly overlaps the last period. In May, 54 were registered and in June-August, 204.

In the period 7/99 up to and including 12/99, 242 men and 185 women were treated at the casualty clinic for injuries.

Indicator Diagnosis

5 women and 1 man are registered in our indicator diagnosis, hip joint breaks. In the 1st half-year there were 2, and in the last half year 4. In total, 6 hip joint breaks.

There is no double registration as regards hip joint breaks in the 1st half year, but double registration cannot be ruled out (check with /JHP) in the last period since, in the same period, there were 4 hip joint breaks at Stoner nursing home.

Hip joint breaks in 1999

Registered at:	Number of hip joint breaks
Stovner nursing home	(4)admitted to Aker hospital
Aker hospital	Waiting for numbers from hospital
Casualty clinic	(6)admitted to hospital
<i>Total</i>	

Handling of injury data for 2nd half year, 1999

A closer study of the numbers in a chosen period is taken, for the purpose of assessing if – and how- we can utilise the material from the casualty clinic.

Is there anything in the material which signals how the district`s health care services can work injury- preventively, or is acquiring of this type of information irrelevant?

Here we have made a further study of the period from 7/99 up to and including 12/99. 242 men and 18 women were treated at the casualty clinic for injuries. The most common injury diagnosis from the casualty clinic`s doctors amounts to 146 registrations, in addition to the injuries related to ICPC diagnosis.

The injuries which are registered most frequently (10 cases) in this period are:

Diagnosis-injury	Men	Women
L72.12 Break in arm – colles type	3	7
L77 Sprain in leg – ankle	21	18
L79.03 Sprain in arm – wrist	8	4
L79.05 Sprain in arm – ip joint	4	6
S16.05 Bruising in arm – hand	9	3
S16.10 Bruising in leg – foot	9	4
S18.06 Soar injury arm – finger	5	17
S18.14 Soar injury axis – face	20	10
Total	79	67

Distribution of the most frequent injuries and injury locations

ICPC – diagnosis no. L72 up to L76.30: 84 different break injuries

ICPC – diagnosis no. L77 up to L79.10: 95 different sprains

ICPC – diagnosis no. L80 up to L80.11: 10 different joints out of sockets

ICPC – diagnosis no.S16.01 up to S16.15 84 different cases of bruising

These main areas comprise a total of 273 registered diagnoses.

Other enquiries/injuries listed - the most frequent registrations in parenthesis:

Accident/injury ina,ika (7), medicine poisoning, rupture of the milt, food poisoning, foreign object/injury to the eye or nose – larynx – bronchial tubes, damage to eardrum, varying cases of pain, varying ruptures, pulled muscles, meningitis, injury to oneself, symptoms in the sinuses,

insect sting (5), bite by an animal or person (6), burnt /scalded (7), foreign object in the skin and symptoms/problems with nails.

A total of 154 registered diagnoses are found in this group, involving from 1 to 7 registered enquiries.

The City of Oslo`s Parliamentary System

The City of Oslo Municipality

The city of Oslo`s municipality is governed according to parliamentary principles. This implies that the city parliament chooses a city government which is responsible to the former, in the same way as the country`s government is responsible to the Norwegian Parliament (Stortinget). In the event of the city government or one of its commissioners having the majority against them in the city parliament, the city government or commissioner must step down (lack of confidence). The city government can also ask for a vote of confidence from the city parliament through a cabinet question of confidence.

The districts are responsible to the city`s Department for Primary Health Care and Social Affairs

This department has the function of employer for the districts` administration managers and has the overall responsibility for most of the districts` fields of responsibility, which are:

Work with preventive health care, physical health care in the districts, environmental health care, the health centres, the districts` physiotherapists, the child health clinics, clinics for pregnant women and the school health care services, agreements with general practising doctors and physiotherapists. All the services involving care of elderly and the disabled. The department is a secretariat for the central Council for the Elderly in Oslo and the Council for the Disabled in Oslo.

The social services, the district child welfare service, drug/alcohol abuse welfare and preventive work, free legal help, action plan against violence, sexual violence and prostitution.

The integration of refugees and immigrants, voluntary work, financial help to various organisations and close-neighbourhood environmental work. The chief responsibility for job training/ qualifying as well as enterprises for occupationally inhibited. The chief responsibility for nursery schools and preventive work with youths. The department is a secretariat for the labour market council in Oslo.

The department has the following sub-functions:

- Refugee and immigrant office
- Free legal help
- Health care authority
- Drug/alcohol abuse authority
- Social emergency services - under Ullevål hospital
- Ungbo (housing for youths)- under the housing and building authorities
- The use of nursing homes outside the city

The department has ownership responsibility for 11 limited companies which provide work for the occupationally inhibited.

The Districts

There are 25 districts in Oslo. Stovner District is described in the introductory part of this application.