

Injury and violence prevention and care

**Report of a regional meeting of national programme managers
Jakarta, Indonesia, 25–27 June 2013**



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Regional Office for South-East Asia

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Acronyms

| | |
|-----------|--|
| DDC | Department of Disease Control |
| HMIS | health management information system |
| IS | injury surveillance |
| MOH | ministry of health |
| NCD | noncommunicable diseases |
| NGO | nongovernmental organization |
| PRECISE | Prevention of child injuries through social intervention and education |
| RSDC | Road Safety Directing Centre |
| SEA | South-East Asia |
| TEACH VIP | Training, Education, and Advancing Collaboration in Health on Violence and Injury Prevention |
| UHC | universal health coverage |
| UNICEF | United Nations Children's Fund |
| VIP | violence and injury prevention |
| WHO | World Health Organization |

Acknowledgements

This regional report is based on information from the Member States of the South-East Asia Region. Grateful thanks are extended to the focal points for injury and violence in the ministries of health in Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste and in the WHO country offices mentioned in the list of participants (*Annex III*) for providing the data for this report.

This document has also benefited from the contribution of several staff members from the WHO Regional Office for South-East Asia, in particular, Dr Chamaiparn Santikarn, Regional Adviser, Disability, Injury Prevention and Rehabilitation, and Dr Salim Mahmud Chowdhury, Temporary International Professional (Technical Officer) in its finalization.

1. Introduction

A regional meeting of national programme managers on injury and violence prevention and care was held in Jakarta, Indonesia, 25–27 June 2013. Participants included WHO focal points for violence and injury prevention (VIP) from the ministries of health from 10 Member States of the WHO South-East Asia (SEA) Region (See list of participants in Annex 3).

1.1 Objectives

General objective

The general objective of the meeting was to strengthen the national programmes on injury prevention and care.

Specific objectives

- (1) to review the current situation of national programme on VIP;
- (2) to share information about the ongoing work of WHO and Ministry of Health (MOH) focal points in VIP; and
- (3) to update the Regional Strategy on Road Safety in the Region.

1.2 Expected outcomes

- (1) updated situation of injuries in the SEA Region and strategies for injury surveillance;
- (2) support and guidance to countries in developing and implementing national policies and plans to deal with

injuries, mainly road traffic, work-related, child injuries and other major injuries;

- (3) support and guidance to countries to deal with self-inflicted violence and gender-based violence;
- (4) exchange of experiences in national VIP;
- (5) establishment of injury unit and mechanism for national programme implementation and coordination with other relevant sectors.

2. Proceedings

Dr Rita Djupuri, Head of Sub-Directorate of Interference due to Accidents and Violence Control, Directorate of Noncommunicable Diseases Control, Indonesia, welcomed the participants, after which the WHO Representative for Indonesia, Dr Khanchit Limpakarnjanarat, delivered a message from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region (Annex 1).

Dr Chamaiparn Santikarn, Regional Adviser for Disability, Injury Prevention and Rehabilitation in the WHO Regional Office for South-East Asia gave a brief introduction on the background, purpose, agenda, programme and expected outcomes of the meeting.

Case scenarios were presented and critically analysed. Essential sessions relating to injury epidemiology, prevention and care, including violence, were organized.

2.1 Injury and violence prevention activities

Global report

Dr Alexander Butchart, Coordinator, Prevention of Violence, WHO/HQ, highlighted the basic principles of injury prevention. Injury is a leading cause of global mortality that boosts the number of deaths caused by road traffic accidents due to more

exposure to risk, less exposure to prevention and less access to quality trauma care and rehabilitation which is mostly found in low socioeconomic countries.

Particular types of injury require specific attention for specific causes, while cross-cutting issues of data, research, policies and legislation, prevention and evaluation, health and social services, and advocacy are required for all types of injury prevention and care.

Involvement of multiple ministries as potential partners to each type of injury were recommended where the MOH is the key ministry to coordinate with suggested paradigm shift from 'response' to prevention and evaluation.

Regional report

Dr Chamaiparn Santikarn presented the situation analysis of Resolution SEA/RC63/R2 on "Injury Prevention and Safety Promotion" adopted by the Sixty-third Session of the WHO Regional Committee for South-East Asia held in 2010.

The recommendations for the Region from self-assessment are that adequate country budget should be ensured by governments and WHO country offices to establish and maintain an Injury Unit in the MOH to (1) support and foster the full involvement of the communities, civil society, private sector, nongovernmental organizations (NGOs) and mass media; (2) support and strengthen injury surveillance, vital registry and other related data systems; (3) integrate injury prevention and safety promotion into a primary health care package including encouragement of operational research; (4) coordinate planning and implementation of the Decade of Action on Road Safety; and (5) support annual conferences for networks of national institutions, academia and individuals working in the field of injury prevention.

A regional factsheet on the status of road safety in South-East Asia for the Second Global Status Report on Road Safety was

launched. Capacity strengthening on injury prevention and care for country focal points in the MoH was undertaken through Training, Educating, and Advancing Collaboration in Health on Violence and Injury Prevention (TEACH VIP 2). Injury prevention was integrated in the training curricula of health professionals, medical and nursing undergraduate studies. The recommendations of the SEA Expert Group to prevent motorcycle injuries to children has been welcomed by all Member States and advocacy for child motorcycle helmets is being initiated by the ministries of health and other relevant ministries in India, Myanmar, and Sri Lanka. (Indonesia and Thailand have already standardized, inexpensive child motorcycle helmets sold and used on the roads and are now exporting them to many other countries in the world).

In addition, multisectoral programme/activities were carried out at country level, such as advocacy for specific national policy and measures on motorcycle and road safety in India, Indonesia, Nepal, Myanmar, Thailand, and Timor-Leste and organization of national workshops to develop plans for implementing the Decade of Action on Road Safety.

The challenges of implementing injury and violence prevention in the Region are as follows:

- weak basic health information and vital registration systems;
- inadequate research capacity;
- no/inadequate alternative, innovative and sustainable sources of financing;
- competing priorities at regional and national levels and insufficient financial support; and
- rapid increase in the number of vehicles, especially motorcycles.

Lastly, multisectoral coordination for actions and an urgent need for vehicle safety specifications and regulation of advertisements that may promote risky behaviours were proposed.

Focal points from respective ministries of health described the salient features of their national VIP programmes.

Country reports

Bangladesh

Injuries are the second leading causes of hospital admission (18%) while 33% of the beds in primary and secondary level hospitals in Bangladesh were occupied by injury-related patients. Among injury-related patients, about 19% had been injured in a road traffic accident and more than 66% were males of reproductive age. The average duration of hospital stay was 5–7 days and average cost was US\$ 86 per patient. The Injury Surveillance (IS) Unit is administered under the Ministry of Health and Family Welfare with a central data pool managed by the Medical Information Services Unit of the Directorate-General of Health Services. From the IS database, road traffic accidents injure 400 000 people a year and kill approximately 18 500. Many road safety initiatives like establishment of National Road Safety Council, preparation of National Road Safety Strategic Action Plans, setting up a National Health Crisis Management Centre and control room have been implemented.

The Health Department implements the Interpersonal Violence Prevention Programme comprising one-stop crisis centres, specialized support to victims and awareness programmes through mass media. Among children aged 1–17, drowning (28%) claimed more lives than other causes followed by pneumonia (20%). Hence, the Government included injury prevention as one of the five priority areas for public health intervention and as a special focus area for children's health. In collaboration with UNICEF, PRECISE (Prevention of Child Injuries through Social Intervention and Education) was implemented with coverage of about 1 million people.

Bhutan

According to the Annual Health Bulletin 2013, the five leading causes of deaths in all ages are alcoholic liver diseases, other respiratory and circulatory diseases, neonatal deaths and cancers. Injuries are not in the reported five leading causes of admission for all ages. Injury surveillance and information system is integrated in the health management information system (HMIS) where basic health units submit information to the district level and further to the central level. As per the HMIS, work-related injuries ranked the first place for injury. In Bhutan, an increasing trend of number of vehicles and road traffic accidents is observed. National Action Plan for the Decade of Action for Road Safety (2011–2020) was approved by the Cabinet and the Road Safety and Transport Authority is appointed as the national lead agency.

For interpersonal violence prevention, MOH does not have a major role, but provides medical treatment and counselling as well as collaborates with police and NGOs for protection of women and children. Major challenges for national injury and violence prevention programme are inadequate capacity of health-care providers in emergency and trauma care management, turnover of trained manpower, no trauma centre, information management – no common data in road traffic injuries-related deaths and budgetary constraints.

India

According to the Statistics Division, during 2001–2003, injuries ranked the third leading major-cause group of deaths after communicable, maternal, perinatal and nutritional conditions and noncommunicable diseases (NCDs). The precise number of deaths and injuries due to specific causes, or any scientific estimates of injury deaths are not available from any single source. Presently, information on injuries is collected through the National Crime Records Bureau where the incidence of injuries and number of deaths were recorded, but not the causes of injury. No central data are maintained for causes of all admissions in

India. However, limited studies revealed that 20–50% of emergency room registrations and 10–30% of admissions are due to road traffic injuries. In the Twelfth Five Year Plan (2012–2017), under the national trauma scheme, an injury surveillance and information system will be established. The leading victims of road deaths are two-wheeler drivers and passengers – (23.2%) of all road user deaths. The challenges of the road safety programme in India are: intersectoral coordination among different ministries, designing of roads and vehicles, education for pedestrians, pre-hospital care, IS database and legislation and enforcement.

There is no systematic data collection system to quantify and qualify the causes of violence in India. The occurrence is high among women, especially those belonging to the lower socioeconomic and younger age groups. Major influences on violence against women are the role and status of women, lack of education and employment opportunities.

The highest proportions of drowning deaths were found among children under five years of age (14%) while the highest proportion of road traffic deaths were found in the age group of 30–39 years (10%) of all unintentional deaths. The injury unit within MOH is yet to be established.

Indonesia

The Injury and Violence Control Unit is administered under the Directorate of NCD. In Indonesia, injury is ranked at the fourth place for leading causes of death at all ages, according to 2007 health research data. Following the launching of the Decade of Action for Road Safety, the National Plan for Road Safety 2011–2035 was announced. Injury surveillance system has been introduced in five sentinel hospitals with various activities such as development of data collection form and manual, training for data collection and development of application system to integrate with the general health information system. Trial for form filling started in Fatmawati hospital (December 2012–May 2013). There is a

tentative plan for injury surveillance training in Fatmawati and Sou Tomo Hospitals during August 2013.

The injury unit in the Directorate of NCD is a part of the Task Force for Violence against Women and Children and Trafficking. Some key outputs delivered by the task force are guidelines for domestic violence prevention and early detection from potential occurrence of injury and violence.

For child injury prevention programme, unintentional falls and road traffic injuries are the first and second causes of injuries among babies, toddlers and children, whereas road traffic injury is the leading cause of morbidity in external causes of injury among children from outpatient and inpatient departments of hospitals.

Maldives

With a total population of 330 652, injury is not reported in the top five leading causes of death, while ill-defined and unknown causes of mortality claim the second rank. According to the national injury information system, death certificate is used for recording all deaths with causes of death together with the causes of hospital admission report, national census survey, police data and databases of other ministries e.g. Ministry of Gender and Family for domestic violence statistics. Since there is no national coordinating unit for injury surveillance, the piloted injury surveillance since 2005 was not implemented as planned; however, the database had been handed over to the Injury Prevention Programme (NCD unit), Health Protection Agency, and the first IS report is expected by 2014.

The Health Protection Agency, MOH is the leading agency for the Maldives road safety programme. Motorcycles are predominant among other types of registered vehicles. The number of deaths from road traffic accidents is relatively low: five, seven and five deaths respectively were reported by the police database in 2010, 2011 and 2012.

Ministry of Health provided health care and treatment for cases of gender-based and interpersonal violence. A national action plan has been developed on health response to violence.

Drowning is not the major cause of death for children in Maldives, even though 99% is covered by sea. The highest number of deaths from drowning was in 2011, when nine deaths from water transport accidents were recorded.

Myanmar

Myanmar's population of 60 million is 70% rural and 30% urban. Injury is ranked second in the hospital information system as a cause of death only after HIV disease. From the National Injury Surveillance Annual Report, road traffic injuries, falls, and assaults are the leading causes of death in all age groups. Over the years, there is an increasing trend of interpersonal violence in Myanmar.

HMIS is a national data collection system where data pertaining to cases and deaths of eight types of injury are contained. The number of registered vehicles is increasing drastically with majority (82%) being motorcycles. Among the regional states and divisions with IS, the fatality rate is the highest in Mandalay followed by Yangon and Nay Pyi Taw which correlated with the number of motorcycle users recorded in each town. The recommendations for improving injury prevention programme in Myanmar are as follows:

- implement pre-hospital care system (emergency medical service) and good quality trauma care;
- establish database for assessing injury cases;
- technical development in district level hospitals;
- collaboration and coordination among concerned ministries and departments (governments and NGOs);
- continuation of injury surveillance system in hospital of states and divisions.

Nepal

Injuries are not among the five leading causes of deaths of all age groups in Nepal in 2010. Road traffic accidents were reported in 2010 as the fourteenth cause. Five leading causes of admission also did not contain injuries but it was tenth in rank of admission. Major existing national injury data sources are police data or the Home Ministry's database for disaster. Since 2008, the injury surveillance system was piloted in eight hospitals (three hospitals each at central, regional and zonal level) with no further continuation, since there is no national coordinating unit for injury surveillance. Among the total number of vehicles registered in Nepal, motorcycles constitute the biggest proportion at 77% and road traffic deaths from motorcycle accidents show an upward trend. Following the Decade of Action on Road Safety, the national action plan on road safety (2010–2020) was approved. Various road safety initiatives have been successfully implemented.

Interpersonal violence prevention is not the mandate of MOH and different departments are responsible for handling different types of interpersonal violence. Unspecified fall following an accident from motor/non-motor vehicle is the major leading cause of injury deaths in children. More than half of the total drowning deaths in Nepal were of children below 18 years. Swimming training has been instituted in formal education, but is provided mostly in private schools in the early stages.

Sri Lanka

Traumatic injury is ranked as the eighteenth leading cause of hospitalization, but at the eleventh rank for hospital deaths. The national policy for injury prevention was established in 2012. The national committee on violence prevention is convened by MOH with interministerial collaboration.

Violence prevention is considered to be a police, legal, personal or family problem. The vehicle population had increased

to almost 5 million in 2012. Situation analysis is required, since it is several years after the first country report.

Thailand

From death certificates, the external causes of morbidity and mortality ranked fourth as the leading cause group of death of Thais in 2012. Two-wheelers are predominant (59%) among registered vehicles in Thailand where the highest percentage (65%) of deaths from road traffic injuries by type of road user in 2012 was from motorcycle. Road Safety Directing Centre (RSDC) is the national body for road safety programme with multiministerial collaboration. The Ministry of Public Health contracted the RSDC to manage and integrate various databases from the police, insurance company, ministries of health and transport into one computer-based system. All databases will be linked by Department of Disease Control (DDC) via computer system.

The Thai Road Foundation conducts an annual survey on the use of seat belt and helmet. Drowning data is available from both death certificates and IS, but there is more coverage on death cases by death certificate. Violence data is available from both death certificates and IS. Interpersonal violence prevention is the responsibility of different ministries while the mandate of the Ministry of Public Health is as follows:

- provision of services for people who have experienced and are affected by interpersonal violence;
- monitoring and evaluation;
- coordination with related organization;
- information support.

Among leading causes of severe injuries among Thai children under 15 years, road traffic injuries, falls and inanimate forces are found as the top three from sentinel hospital-based IS data. Drowning causes the highest mortality rate (8.7–9.8%) compared to traffic accidents (4.5–7.1%) in the same group,

according to death certificate data. Child drowning prevention programme has been implemented by the Ministry of Public Health since 2006, achieving a gradual reduction in child mortality rate.

Timor-Leste

The country has a total population of 1.2 million in 30% urban and 70% rural areas, with dispersed villages isolated by mountainous terrain and poor roads. Communicable diseases are the leading cause of deaths in all age groups. With the growing number of registered vehicles over the years and increasing vehicle speed due to widespread road networks, road traffic injuries are foreseen as a growing problem in Timor-Leste. By 2020, there could be over 300 deaths and 2000 serious injuries per year, where more than half of the victims will be motorcyclists and pedestrians. Challenges towards road safety interventions are: limited human resources in terms of quality and quantity, equipment and road infrastructure.

2.2 Draft regional framework on road safety in the South-East Asia Region

The draft regional framework on road safety in the South-East Asia Region highlighting the burden of road traffic injuries in the Region and identified different areas for research including methodological aspects was presented and discussed. The document was finalized with inputs from participants.

2.3 Institutional roles and responsibilities on violence prevention

Dr Nopporn Chuenklin, Deputy Director-General, Department of Disease Control, Ministry of Public Health, Thailand led the discussion on the roles and institutional responsibilities on violence prevention in the ministries of health.

Concern was expressed by the countries that when the key responsibility for violence prevention is within the purview of the Ministry of Social Development, what exactly is the role of the Ministry of Health? It was felt that a multisectoral and ministerial approach with a national committee is the way forward for long-term intervention in this area.

Dr Prakit, Temporary Adviser, opined that a multiministerial approach requires designated organization, capacity-building and a comprehensive programme. Involvement of respective ministries as well as political and social commitments are the keys to success. He suggested that a technical working group be set up among core ministries with assignment of specific issues to specialized agencies.

Dr Butchart reiterated the importance of the paradigm shift from response to prevention. Injury and violence prevention is included in post-2015 agenda. The focus of the Global Status Report on Violence is limited to interpersonal violence; war and political fighting related violence are not included.

Several MoH focal points informed that violence is not the main responsibility of the MOH. To advance the issue, clear tasks should be assigned to specific departments in the Ministry.

After discussions, it was agreed that there should be designated responsibility for a specific department in the MOH to implement and coordinate the issue with multisectors and encouraged that MOH should reflect the magnitude of violence to policy-makers. For Thailand, the Ministry of Public Health will coordinate with the Ministries of Interior and Social Development and Human Security for instituting a national scheme for violence prevention.

2.4 Alternative, innovative and sustainable sources of financing for violence and injury prevention and safety promotion; and related operational research

Dr Prakrit Vathesatogkit, Adviser to the Thai Health Promotion Foundation presented a case study from the Foundation to demonstrate alternative, innovative and sustainable sources of financing for VIP and safety promotion; and related operational research. The following were the salient points made:

- A working group, chaired by Dr Prakrit, was appointed to set up the Health Promotion Foundation, with the objective of securing funding to support tobacco control and health promotion programmes, especially for alcohol-related problems, road traffic crashes and cardiovascular diseases.
- In order to generate more support, the Health Promotion Foundation Bill was drafted as well as evidence collected to show that investment in a health promotion fund is cost-effective.
- Two key features of the Health Promotion Foundation Bill are: (1) sustainable funding source; and (2) an autonomous project-based health promotion agency, with flexible management, not bureaucracy-driven, and hence less susceptible to administrative/political interference.

The budget required for setting up a health promotion foundation was proposed at about 200 million baht (US\$ 67 million) – which is 2.85% of the budget of the Ministry of Public Health and 1% of national health expenditure. A 10% reduction in tobacco, alcohol-related problems/traffic accidents, could result in an annual saving of US\$ 500 million. It was proposed that 2.5–3% of revenue generated from tobacco excise taxes, about 700 million baht (US\$ 23 million) amounting to 10% of the Ministry of Public Health budget, should be earmarked for this purpose. The Ministry of Finance disagreed, as this had never happened in Thailand before. There was lobbying by several groups through different channels, including by doctors in the main tertiary care

teaching hospitals. The funding was eventually adjusted to an additional 2% over and above the revenue generated from the excise tax. The Finance Minister eventually supported and also recommended addition of revenue from alcohol excise tax to that from tobacco. Public opinion supports using sin tax to fund health promotion that can save health-care budget.

The Health Promotion Foundation Act was approved in 2001 after the new government policy on universal health coverage (UHC) was issued. The Thai Health Promotion Foundation was established as an autonomous state agency. Two percent of alcohol and tobacco surcharged taxes will go towards funding this Foundation. The Act covers the objectives/mission of the Foundation, source of funding, structure and functions of the governing board, organization of health promotion office, evaluation, auditing and monitoring processes, reporting to the Cabinet/Parliament. Transparency and accountability are clearly emphasized. More detailed information will be available in the WHO publication on this topic to be published in 2014.

The broad scope of the Foundation makes it more appealing to the politicians and public, enables it to have more allies and deflect the position of tobacco industries. In 1996, to publicize the concept of using tobacco tax to fund health promotion based on the model of the Victorian Health Promotion Foundation, Australia (VICHealth), the core team arranged for the CEO of VICHealth to advocate it with the Minister of Finance. The lessons learnt from the Thai experience are summarized as follows:

Lessons learnt from the Thai experience:

- do good homework;
- prepare robust research data;
- build a critical mass to support adoption;
- approach the right policy makers;
- frame it as an economic issue;
- government does not have to fund it or to lose the present income;
- use international examples;
- be patient, do not settle for less;
- should be legislated;

2.5 Self-assessment of implementation of Resolution SEA/RC63/R2 and the way forward

A self-assessment of implementation of Resolution SEA/RC63/R2 on “Injury Prevention and Safety Promotion” and the way forward for regional priorities, strategies and report for 2014 was conducted. The findings were as follows:

- The highest level of progress is on road safety and violence prevention. Three out of the 11 countries have made satisfactory progress. Budget constraint is the key challenge for implementation, especially in establishment and strengthening of the injury unit and injury information system. Only four countries reported having an injury unit in MOH.
- Adequate country budget provision should be ensured by governments and WHO country offices to:
 - establish and maintain a functional injury unit in MOH (with two full-time technical staff);
 - support and foster full involvement of communities, civil society, private sector, NGOs and mass media;
 - support and strengthen injury surveillance, vital registry and other related data systems;
 - integrate VIP into maternal and child health and primary health care packages;
 - encourage operational research on innovative funding source for VIP and intervention;
 - coordinate planning and implementation of the Decade of Action on Road Safety; and
 - support conference-networking of national institutions, academia and individuals in VIP.

A discussion on injury priorities and strategic approaches at regional level from 2014 onwards followed. The regional priorities in injuries for the years 2013– 2014 were ranked in the following

order – road traffic injuries, drowning, violence (excluding war and political violence), falls, and burns.

The regional strategies and approaches agreed upon were as follows:

- systems approach;
- population-wide approach rather than high risk approach – targeting change in the population as a whole than focusing on change in the high-risk group, which is of a small proportion only;
- multisectoral coordination including development of innovative budget mechanism or earmarked government budget;
- coordination for actions:
 - more focus on medical and health professionals function – guidelines, standards, curriculum development and training;
 - other sectors – NGOs, media, school, police and other concerned ministries;

Participants were informed that a progress report was to be finalized by May 2014 – about one-page summary with three-page report for submission to the Sixty-seventh Session of the Regional Committee in 2014 which would be based on data from the self-assessment and from end-of-biennium assessment and recommendations.

2.6 Establishment, development and functions of injury unit in MOH, Indonesia

Dr Rita Djupuri briefed the participants on the establishment, development and functions of the injury unit in MOH, Indonesia. The Injury and Violence Control Unit is administered under the Directorate of NCD with the main task of (1) formulating materials; (2) preparing for implementation of policy, norms, standards, procedures and criteria; (3) providing technical assistance,

collaboration and partnership; (4) monitoring evaluation; and (5) submitting progress reports on injury and violence areas. A national policy and action plan for road safety are in place and an injury surveillance system developed in five sentinel hospitals. The MOH is a part of the taskforce for multiministerial coordination on violence prevention and anti-trafficking activities.

In the ensuing discussion, the following points were made:

- Clarifications were provided about the budget and status of injury units in India and Sri Lanka, and the findings from the self-assessment will be reviewed and amended with the updated information to be provided through the WHO country office.
- Regarding regional approach, Dr Butchart suggested that high risk group approach may still be needed, especially for teenaged mothers.
- Key success factors for setting up an injury unit were identified as: need and commitment from policy-makers, assigned focal point and adequate budget.

3. Field visit to a private transport company, Jakarta

MOH arranged and hosted the field visit to a private transport company in Jakarta. In terms of technical collaboration with the Ministry of Transport, this company provided routine check-up services and maintenance of buses; driver training programme; and certification for safe drivers. MOH is providing training to the personnel of the company for health examination of bus drivers on special occasions. The examination will include routine testing for blood pressure, blood glucose, amphetamine within urine sample, and blood alcohol concentration. This company has carried out projects for road safety such as ecodriving project, and establishment of emergency service points in collaboration with local vendors for providing rest areas, basic medical care and mechanic services in 13 locations throughout the country.

4. Conclusions and recommendations

The regional meeting of national programme managers on injury and violence prevention and care held at Jakarta, Indonesia, from 25–27 June 2013, was attended by participants from 10 out of 11 Member States of WHO South-East Asia Region.

4.1 Conclusions

The meeting agreed that some recommended actions from Resolution SEA/RC63/R2 on Injury Prevention and Control adopted in 2010 did not progress well enough due to inadequate allocation of budget by WHO and governments. The meeting also agreed on the updated priorities in the violence and injury area, which are: road traffic injuries, drowning, violence (self-harm and interpersonal violence), falls and burns; with children, women and the elderly as primary target groups. The strategic approaches for injury prevention and safety promotion were also updated and agreed upon for proposing to the Sixty-seventh Session of the Regional Committee in 2014. The draft regional framework on road safety was examined, improved and agreed upon.

4.2 Recommendations

For SEA Member States:

- (1) Adequate funds should be allocated to the activities to be urgently conducted as recommended by Resolution SEA/RC63/R2 including:
 - (a) establishing/maintaining an injury unit in MoH;
 - (b) supporting and fostering the full involvement of communities, civil society, private sector, NGOs and mass media;
 - (c) supporting and strengthening injury surveillance, vital registry and other related data systems;

- (d) providing more information on emerging issues such as child injury and maltreatment, drowning and burns;
 - (e) integrating VIP into PHC packages;
 - (f) encouraging operational research on innovative funding sources for VIP and interventions;
 - (g) coordinating planning and implementation of the Decade of Action on Road Safety;
 - (h) coordinating multisectorally with NGOs, private sector, media as well as lawyers; and
 - (i) supporting conference-networking of national institutions, academia and individuals in VIP.
- (2) Evidence-based national policy, plans and strategy for VIP and care should be developed in all Member States.
- (3) Capacity building should be further strengthened as the concepts in violence and injury are changing from care to prevention. For violence, prevention is the most effective intervention.
- (4) Ministries of health should play an important role in VIP and safety promotion as stimulation for other sectors and ministries as well as advocate for action and take the lead in:
- (a) data collection and advocacy;
 - (b) research, evaluation and monitoring;
 - (c) coordinating prevention strategies involving parenting support and reducing access to and harmful use of alcohol;
 - (d) coordinating delivery of services for victims of violence; and
 - (e) defining and designating the department(s) and units to implement and coordinate VIP.

- (5) The draft regional strategic framework on road safety has been endorsed with an additional strategy, making a total of 12 strategies.
- (6) In addition to Resolution SEA/RC63/R2, important strategies were adopted by the meeting for Member States to implement and focus on development of health services and enhancement of multisectoral collaboration as follows:
 - (a) The ministries of health should integrate injury prevention into the core health programmes and services such as the planned-parenthood programme/clinics, ANC services, parental training/counselling services, well-baby clinics, school health services, occupational health and medicine clinics and home visits. VIP should also be integrated into the concerned guidelines and handbooks. The capacities of the health personnel of hospitals/clinics, emergency rooms, pre-hospital services, and all doctors and nurses should be strengthened in VIP so that they can provide education on safe behaviour practices to their clients to prevent severe violence and injuries.
 - (b) The ministries of health should coordinate with the concerned authorities to improve medical certificate form for driver licence examination to ensure all drivers are medically fit to drive. Certain types of medical conditions that may affect the person's ability to drive safely should be included.
 - (c) Medical and nursing councils should encourage members to educate their clients on important safe behaviours to prevent major injuries (such as use of helmet by children and adults, not driving after drinking, close supervision and practices to avoid drowning).
 - (d) Advocacy and coordination must be undertaken with concerned organizations for nursery, kindergarten

and primary schools to have national standard curriculum to educate children in life skills in safety (especially road safety and water safety for drowning prevention). Training/workshops for teachers and nursery caretakers to implement the curriculum should be provided regularly.

- (e) National institutes for standards, consumer protection councils, and broadcasting corporations should be advocated to regulate motorcycle safety standards checklist and advertisements/movies/TV series/spots that promote risk behaviours in the population.
- (7) Innovative and sustainable funding for multisectoral initiatives in safety and health promotion should be initiated for sustainability.
- (8) Ministries of health and road safety networks should consider initiating positive approach activities to promote better road safety enforcement, such as an award to the police [Indonesia, Myanmar, Sri Lanka and Thailand expressed interest to pilot within the country with collaboration with WHO country office and the Regional Office to explore the possibility of scaling up to be a regional award].

For WHO:

- (1) WHO should advocate for adequate allocation of budget to the injury prevention and safety promotion programmes as recommended in Resolution SEA/RC63/R2 and propose additional strategies and activities in the health sector context (point 6 above), taking the opportunity to report the progress made by the injury prevention and safety promotion programme in the Region to the Sixty-seventh Session of the Regional Committee for further endorsement.
- (2) Member States should be encouraged and supported to carry on the activities in accordance with the Resolution

that do not show satisfactory progress, and also the additional activities agreed on in this meeting.

- (3) Technical support and opportunities should be provided for exchange of information among Member States in the Region.
- (4) Monitoring and evaluation of injury programmes in the Member States should be supported.

Special recommendations to reduce road traffic injuries:

- (1) multisectoral approach;
- (2) designation of lead agency at the highest level with active involvement of health sector;
- (3) capacity-building of personnel working in road safety in different sectors, including first responder for pre-hospital care;
- (4) comprehensive programmes to improve road safety behaviours;
- (5) education and public awareness by new or stricter law enforcement;
- (6) integration of road traffic injury prevention with core health functions;
- (7) sharing knowledge, evidence and information and networking;
- (8) data generation for policy planning;
- (9) improved vehicle safety and regulation on advertising and marketing of vehicles;
- (10) development of sustainable alternative commuting systems;
- (11) improved road infrastructure;
- (12) innovative and sustainable mechanisms for multisectoral funding in road safety;

Annex 1

Message from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region

Injuries from traffic crashes, drowning, poisoning, falls, burns, assault, self-inflicted and acts of war kill more than 5 million people worldwide annually and cause harm to millions more. Injuries account for 9% of global mortality, and are a threat to health in every country of the world. In addition, large proportions of people surviving their injuries incur temporary or permanent disabilities.

Unintentional and intentional injury causes a significant number of deaths, human suffering and disability in the WHO South East Asia Region every year. WHO and its Member States are committed to prevent injuries, violence and disabilities and reduce the consequent suffering. WHO's role is to provide scientific and evidence-based information and technologies to the Member States; to ensure that every person in the Region lives his or her life to its fullest potential.

In this contest, collaboration needs to be further strengthened between academia in countries of the Region to initiate operational research to develop sustainable prevention mechanisms and to implement them in a coordinated way in the Region. For coordinated action, sharing experience and knowledge is indispensable. Further, programmes such as, the Decade of Action on Road Safety 2011–2020, implementation of the resolution of the Regional Committee for South East Asia on tapping alternative, innovative and sustainable sources of financing requires updated information and wholehearted efforts of Member States as well as the enthusiastic leadership of programme managers.

For effective implementation of VIP activities at the country level, programme managers play a pivotal role. I urge the programme managers to effectively participate in the meeting and

extend collaboration within and between countries in the Region to achieve the best to safeguard people from all forms of violence and unintentional injuries.

I believe this programme managers' meeting will reinforce WHO's commitment to support Member States in developing and implementing national policies and plans to prevent and manage road traffic and other major injuries; and will pave the way to strengthen capacity for prevention of injuries and violence.

WHO works with partners to prevent injury and violence through scientifically credible strategies that are conceived and implemented in relation to causes at the levels of the individual, family, community and society.

In conclusion, I affirm the strong commitment of WHO to work together with partners to make significant contributions towards prevention of violence and injury. I urge all governments in the Region to work in collaboration with civil society, academia and industries to take orchestrated action in this regard.

Annex 2

Agenda

- (1) Update on global violence and injury prevention
- (2) Regional collaboration on violence and injury prevention
- (3) Assessment of implementation of Regional Committee resolution
- (4) Exchange of country experiences in violence and injury prevention
 - Injury information system and policy for action
 - Establishment of injury unit and mechanism for national programme implementation and coordination with other relevant sectors
 - Alternative, innovative and sustainable sources of financing for injury prevention and safety promotion with special focus on operational research
 - National programmes on violence and injury prevention, Decade of Action on Road Safety, drowning and child injury prevention
- (5) Field visit to injury unit, Jakarta, Indonesia
- (6) Review and update of regional priorities, strategies for violence and injury prevention and road safety

Annex 3

List of participants

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The Meeting of national programme managers on injury and violence prevention and care was held in Jakarta from 25–27 June 2013. The main thrust of the meeting was to strengthen national programmes on injury prevention and care in the Member States.

Participants shared injury and violence prevention status and existing interventions in their respective Member State. Global and regional activities on injury and violence prevention were discussed. Discussions were also held on Implementation of Regional Committee Resolution SEA/RC63/R2 on injury prevention and safety promotion and the way forward for regional priorities, strategies and report for the Regional Committee in 2014.

A number of recommendations were made including establishing and maintaining an injury unit in the ministry of health to address the toll of injury and violence in the Region.



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