

Summary report on the

Regional meeting of ministry of health focal persons for injury prevention

WHO-EM/HLP/085/E

Amman, Jordan
23–25 June 2014



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Organization**

Regional Office for the Eastern Mediterranean

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1. Introduction

Every year almost half a million people die of injuries in the Eastern Mediterranean Region, accounting for about 11% of all deaths. These figures are probably much higher at present, in view of emergency situations afflicting many countries in the Region. Active ages are the most affected. Almost 60% of all regional deaths among males aged 15 to 29 years are attributed to injuries. Road traffic collisions followed by collective violence and suicide are the leading causes of injury deaths in the Region. More alarming is the fact that the problem is on the rise. Leading injury causes of death are projected to move upwards along the list of the top 20 causes of death both in the world and the Eastern Mediterranean Region, if current trends persist.

Concerned by the situation and capitalizing on related global and injury prevention efforts, Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean, designated injury prevention as a priority programme in the WHO Regional Office for the Eastern Mediterranean. A five-year plan 2013–2017 was developed for the regional programme, with a focus on road traffic injuries and trauma care.

Taking a step further in continuation of WHO's ongoing collaboration with ministries of health to coordinate and facilitate national efforts, the WHO Regional Office, in collaboration with the Ministry of Health of Jordan, organized a regional meeting of ministry of health focal persons for injury prevention in Amman, from 23 to 25 June 2014.

Twenty focal persons from 17 countries in the Region participated in the meeting. The meeting aimed to review the current

injury prevention situation and plans, with special focus on road traffic injuries, violence and child injuries, to ensure harmonization of global, regional and national efforts, to examine related regional and global updates and see how they can be translated into action at country level and to agree on the way forward in a structured manner.

The meeting was opened by Dr Bashir Al-Qaseer, Director of Primary Health Care, Ministry of Health, Jordan, and Dr Haifa Madi, Director of Health Protection and Promotion, WHO Regional Office. Dr Madi delivered the Regional Director's opening remarks in which he stressed that injuries could be prevented. Some of the best buys in public health were related to injury prevention. Cost-effective solutions requiring simple technology had enabled developed countries to reduce injury-related morbidity and mortality. Similar successes could be achieved in countries in the Region by the appropriate transfer of these actions. To achieve this end, the health sector had a central role within the broader circle of multisectoral action. Dr Alwan thus hoped that the meeting would only be a first important step towards stronger and more structured collaboration between WHO and ministries of health for stronger injury prevention work.

Dr Bashir, Ministry of Health, Jordan, expressed appreciation and support of national and regional efforts for the prevention and control of injuries and violence in the Region. He emphasized that a major ambition was to institutionalize injury prevention in concerned ministries and institutions by establishing departments to follow up implementation of developed plans in coordination with all concerned parties. During the meeting presentations introduced different subjects on injuries and their prevention. The global situation was presented by the Director of the Violence and Injury Prevention programme at

WHO headquarters. A presentation on the related regional situation and efforts and multisectoral action for injury prevention was given by Dr Haifa Madi, Director, Division of Health Promotion, in the WHO Regional Office. The regional injury prevention team gave presentations on the expected role of health, advocacy for prevention, evidence and data, specific injuries (road traffic injuries, violence and child injuries) and planning for injury prevention. Capacity-building and trauma care aspects were addressed by the Director of the WHO Collaborating Centre for Emergency Medicine and Trauma Care, Aga Khan University, Pakistan. Country experiences were also presented. Discussions took place in the plenary and in groups resulting in a number of recommendations for ministries of health and WHO.

2. Summary of discussions

Violence and injuries are serious public health and development problems globally and in the Eastern Mediterranean Region and the world. The resultant burden is unacceptably high and increasing in terms of mortality and morbidity, particularly among the youth, and socioeconomic implications are grave. Besides the burden, evidence also shows that injuries can be prevented through proven cost-effective interventions that have proven successful in many countries across the world. Nevertheless, violence and injury prevention and control are not receiving the appropriate levels of attention commensurate with this burden and with declared global and regional commitments. In response, over the past decades, WHO and partners have embarked on different global and regional initiatives to address this problem. However, all of these efforts remain meaningless until they are taken up and implemented at the country level where change can really happen.

The health sector, led by the ministry of health, has a vital role in injury prevention in partnership with key non-health sectors within the broader multisectoral action. As injury prevention focal persons strive to fulfil their expected roles, they face a number of challenges. Such challenges can include injury prevention not being considered a priority by ministries of health, lack of needed administrative or financial support, data-related issues, inadequate programmatic or policy-related actions, focus on care and services with no consideration of prevention-related roles, high turn-over of focal persons after they have gained essential knowledge and expertise. The stronger the injury prevention programme is in ministries of health, the more capable it is of developing meaningful partnerships with non-health sectors for more comprehensive and stronger multisectoral action.

The need for multisectoral collaboration arises from the diverse nature of the injury problem, which has multiple determinants, affects many people and sectors, and requires action by different sectors. Such multisectoral collaboration increases access to resources, shares responsibilities and strengthens ownership of activities. To meet its intended objectives, collaboration needs to be organized around complementary issues at international, regional, national levels.

Evidence-based injury prevention advocacy is of utmost importance noting the inadequate attention to injuries, the prevailing misconception about their magnitude and preventability, the lack of funding available for prevention, and the misunderstanding of the exact role of the health sector in different aspects of prevention and control. Advocacy should target policy-makers to generate political will, enhance allocated funding and resources; and promote desired changes in policies and programmes. It should also aim to correct

public misconceptions and generate a demand for safety and target non-health stakeholders within and outside the government to build partnerships and foster collaboration.

Structured and systematic collection, analysis and use of quality data is important to identify the nature and magnitude of injury problems, as well as factors that increase the risk of injury and factors that are potentially modifiable. Data are also important to plan for and assess prevention measures and monitor progress of implementation of related interventions. It is thus crucial to ensure the existence of an ongoing injury data collection or surveillance mechanism within the ministry of health. In addition, coordination with concerned sectors is vital to ensure that data are comprehensive.

Data on the economic cost of injuries and cost-effectiveness of prevention interventions are very important in addressing exchequer concerns of policy-makers. The regional initiative for developing a standardized methodology for the estimation of the economic cost of road traffic injuries was presented and fully discussed.

Improving the full spectrum of post-injury care, including trauma care and rehabilitation, was also discussed. While prevention remains the primary method for reducing the health impact of injuries, it is important to address the whole continuum of response from prevention to care. When prevention fails, an efficient and effective trauma care system should be in place to save lives and prevent short- and long-term disabilities. Discussion revolved around perceptions of ministries of health of the level of effectiveness of different strategies in reducing injury deaths, required areas of capacity- building to improve trauma and emergency care and the main barriers to implementation of inclusive trauma system in high-income, middle-

income and low-income countries. The regional WHO instrument to profile trauma care services was also presented and many participating countries expressed their interest in piloting the instrument. The essential but forgotten rehabilitation part of the comprehensive post-injury response was also briefly discussed, including the need for cross linkages and clear referral mechanisms with concerned programmes within and outside health.

Specific types of injuries, namely road traffic injuries, violence, child-related injuries, as well as burns and drowning, were also addressed during the meeting. Related global and regional WHO commitments and initiatives were discussed, such as the road traffic injury and child injury prevention regional frameworks and the production of Arabic versions of WHO guiding documents on health sector response to violence against women and children.

Multisectoral and health sector planning for injury prevention and control can not be overlooked. The draft strategic framework for road traffic injury prevention was intensely discussed by working groups to ensure that it reflects country views and concerns, as ultimately this framework should be implemented at country level.

Implementation on various aspects of injury prevention and control require the appropriate development of needed capacities. However, there are many settings around the world where public health training does not address injury-related issues. Medical training teaches treatment of trauma but overlooks prevention. At many times, government staff in concerned sectors have neither received injury-related training nor work within structures that allow for coordinated sharing of information relevant to injury prevention. It is important to understand that capacity-building needs to be addressed in a sustained

way, based on a clear strategy and a plan drawing on identified country needs.

3. Recommendations

To Member States

1. Include violence and injury prevention and safety promotion in national health plans and strategies.
2. Establish/strengthen a violence and injury prevention and control programme/unit with an assigned focal person by the ministry of health. The role of the focal person is to cover/coordinate all injury- and violence-related activities.
3. Develop country documents based on an in-depth analysis of the situation of injuries, including policies, data, services, coordination mechanisms, etc. (by the end of 2014).
4. Develop a comprehensive national multisectoral injury prevention and control plan based on the undertaken analysis (by the end of 2014).
5. Ensure the existence of an ongoing injury data collection/surveillance mechanism within the ministry of health. Coordination with other sectors is also crucial to ensure complementarity of data.
6. Implement the WHO instrument to profile trauma care services to strengthen pre-hospital and hospital care as part of the continuum of response.

To WHO Regional Office

7. Provide technical support to Member States in developing country injury documents and injury prevention plans.
8. Develop a basic injury prevention capacity-building online course to be undertaken by all ministry of health focal persons (by the end of September 2014).
9. Finalize the strategic framework for road traffic injury prevention and for child and adolescent injury prevention (by the end of September 2014).
10. Undertake a rapid assessment of existing injury data sources in Member States to identify specific needs at country level and provide appropriate support to address them (by the end of September 2014).
11. Form a working group for child injury and violence prevention. The group shall be formed of WHO and focal persons. The group will meet to identify and agree on a road map to address child injury and violence.
12. Provide clear guidance to Member States on the severity classification of injuries.
13. Support Member States in implementing the WHO instrument to profile trauma care services, and possibly develop a regional report on trauma care systems in the Region (time frame depends on availability of funding).

14. Finalize the regional standardized methodology for estimation of economic cost of road traffic injuries (by the end of 2014) and support its implementation by Member States, as requested.
15. Provide high-level WHO support for the injury prevention programme, by communicating the outcomes of this regional meeting, to senior decision-makers in ministries of health.



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