

Developing policies to prevent injuries and violence:

guidelines for
policy-makers
and planners



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Edited by
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and Rick Waxweiler



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Foreword

Injuries and violence are threats to health in every country of the world. Worldwide, more than five million people die each year as a result of some form of injury and many more remain disabled for life. Given current trends, the global burden of injuries and violence is expected to rise considerably during the coming decades, particularly in low-income and middle-income countries. Despite the growing significance of this problem, few countries have national policies, strategies or plans of action for injury and violence prevention.

The *World report on violence and health* and the *World report on road traffic injury prevention* were launched by WHO in 2002 and 2004, respectively, in order to bring these issues to the attention of world leaders and to provide recommendations for action. These reports were endorsed by the World Health Assembly — the annual global gathering of Ministers of Health — in resolutions WHA56.24 (Implementing the recommendations of the *World report on violence and health*) and WHA57.10 (Road safety and health). Both encourage governments to develop national, and by extension local, policies for injury and violence prevention.

Comprehensive policies and well-thought out action plans are essential if injury prevention efforts are to be effective. Developing such policies, strategies and plans of action is, however, not easy. It requires a number of pre-conditions, including the identification of focal points to lead the effort, the establishment of links across ministries and with civil society and other stakeholders, and political commitment at all levels.

WHO recommends that policy documents for injury and violence prevention contain concrete proposals for action, in the form of objectives, priorities, timetables and mechanisms for evaluation. They should be developed in a participatory manner, involving both government and nongovernment actors alike, and responsibility for various stages of their design and implementation appropriately assigned. In addition, policy-makers and planners should take into account at an early stage the human and financial requirements that will be needed.

The present document, *Developing policies to prevent violence and injuries: guidelines for policy-makers and planners*, describes the necessary steps for creating an injury and violence prevention policy instrument. It also explains the rationale behind the need for such tools, the importance of the health sector in their development and the link between policies and legislation. Guidance on how to implement policies will be developed in a separate document.

One of the annexes attached to these guidelines lists examples of national (and subnational) policy documents for injury and violence prevention and control currently being implemented by various countries around the world. The documents, which are accessible through the web site of WHO's Department of Injuries and Violence Prevention (www.who.int/violence_injury_prevention/policy/en/), may serve as inspiration for policy-makers and planners in other countries in need of guidance in this area.

I express the collective hope of all who have contributed to this project that these guidelines will help to shape the global response to injuries and violence, making the world a safer and healthier place for all.

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List of abbreviations

BAC	Blood alcohol concentration
CEN	Comité Européen de Normalisation [European Committee for Standardization]
EMS	Emergency medical services
FGM	Female genital mutilation
IATAS	International Academy of Television Arts and Sciences
ISBI	International Society for Burn Injuries
ISL	Institute Sicher Leben (Austria)
ISO	International Organization for Standardization
NGOs	Nongovernmental organizations
RTI	Road traffic injuries
TRIP	Traffic-Related Injury in the Pacific project
UK	United Kingdom
UN	United Nations
UNDAF	United Nations Development Assistance Frameworks
UNICEF	United Nations Children's Fund
USA	United States of America
WHA	World Health Assembly
WHO	World Health Organization
WNC	Women National Council

Introduction

These guidelines are intended to assist those wishing to develop national policies to prevent injuries and violence. They cover all the steps that are necessary for developing such policies, up to and including approval by governmental and political authorities. This document does not, however, provide detailed guidance on how to implement policies for injury and violence prevention.

The guidelines are primarily aimed at representatives of government ministries that are concerned with violence and injury, in particular, ministries of health, transport, justice, interior, welfare, family affairs, education, housing, labour, agriculture, sport and consumer affairs. However, this is not to say that these guidelines would not be of interest to others, for instance:

- policy-makers and other decision-makers working in the public health sector;
- nongovernmental organizations (NGOs) working in the field of violence and injury prevention;
- academics involved in research on the causes, treatment and impact of injuries, and in the development and evaluation of appropriate solutions;
- international organizations who wish to support national efforts to prevent and reduce the consequences of violence and injuries, including funding agencies, bilateral donors and United Nations agencies.

Bearing in mind the unique nature of the epidemiological, political and economic situation in individual countries, particular care has been taken in drafting these guidelines to avoid being overly prescriptive. The balance between generic guidelines that cater for everybody's needs and practical hands-on "how to" advice is, however, always difficult to strike. In an attempt to strike that balance, the authors of this document have drawn heavily on the experiences of different countries worldwide, using these as case studies to emphasize key aspects of the policy development process. Furthermore, and to give those charged with the task of drafting a policy document examples of what other countries have done, a comprehensive list of existing policy documents (with details of Internet access where available) is attached to these guidelines as Annex I.

Part I. Setting the scene

Injuries and violence: a serious threat to health

Injuries are a threat to health in every country of the world. Each year, more than 5 million people die as a result of some form of injury and among 15–44 year-olds, injuries are one of the leading causes of death and morbidity (1). If current trends continue, the global injury burden will rise dramatically by the year 2020, with road traffic injuries, interpersonal violence, war and self-inflicted injuries making the largest contribution to the predicted increase in the number of injury deaths worldwide. Injury death rates are significantly higher in low- and middle- income countries, which already account for more than 90% of the world's deaths from injuries and violence.

Mindful of the need to raise awareness about the impacts of injuries and violence on public health, WHO has in recent years embarked on several high-profile initiatives to document the extent and causes of the problem and, moreover, to propose ways to deal with it. In October 2002, WHO launched the first *World report on violence and health* (2). This report was endorsed, in May 2003, at the Fifty-sixth World Health Assembly (WHA) in resolution WHA56.24 (Implementing the recommendations of the *World report on violence and health*), and was supported by the publication shortly thereafter of a guide on how to implement the recommendations of the *World report on violence and health* (3). Subsequently, in April 2004, WHO published the first *World report on road traffic injury prevention* (4), which was also endorsed by a World Health Assembly resolution (resolution WHA57.10 on Road safety and health). Both of these WHA resolutions, the full text of which is reproduced in Annex 2, encourage governments in general and ministries of health in particular, to develop national, and by extension, local policies for violence and injury prevention.

Global efforts to raise awareness of the significance of injuries and violence are increasingly being taken up at the regional level. For instance, a number of resolutions relating to violence and injury prevention have recently been adopted at WHO regional committee meetings, including one on the prevention of injuries in the WHO European Region (5), and in the WHO African Region, one on child sexual abuse (6).

Why is it important to develop policies on injury and violence prevention?

The idea of injury prevention is not new in the sense that all countries have in place laws and regulations that address at least some of the issues associated with violence and injury, and in some steps have already been taken to tackle the consequences of injury and violence. However, in many countries, awareness about the magnitude of the problem is low, with the result that these initiatives are often inadequate and fragmented. Moreover, in view of the complex nature of violence and injury problems, prevention efforts demand multisectoral and multidisciplinary contributions from all levels — local, regional and national. For these contributions to be coherent, they need to be guided by a common vision, common objectives and common strategies. Formulating an injury prevention policy not only gives coherence and visibility to the issue at the political level, but also allows identification of possible conflicts and inconsistencies in different pieces of legislation, and facilitates the optimum use of resources. A national scale movement offers the added advantage of making sure that limited resources are shared among communities with diverse capacities and levels of socioeconomic development. Certain measures, such as creating a safe road infrastructure and establishing and enforcing safety rules in manufacturing, need standardized practices across geographical boundaries and jurisdictions to ensure their effectiveness and efficiency, action that is only served by a national response.

Defining a shared vision and common values should help to unite all those who are involved in violence and injury prevention, such as the government sector, NGOs and community stakeholders, and in turn ensure that efforts are channelled in the same direction. It will also help to define the respective roles and responsibilities of the various government ministries (i.e. health, education, justice, interior, welfare, transport, infrastructure, family affairs, works and labour), who all have a vested interest in injury prevention. The process of formulating policy should also focus attention on the issue of obtaining adequate resources with which to address the problem. In addition, policy development could lead to legislative appropriations, thereby providing a more solid base for budgetary allocation. Having an injury prevention policy is thus the key to the efficient organization of national and community-level interventions in a manner that avoids overlap and gaps in programme development.

The experience of high-income countries indicates that national injury prevention policies can and do work. Over the past 10–20 years, many industrialized countries have reduced their injury death rates, some by as much as half. These reductions can be attributed to concerted and sustained injury prevention efforts, often instigated by government as part of a national strategy or programme. National strategies have been especially effective in reducing injuries in countries such as Australia, Canada and France. Canada's approach has been fairly unique, but nonetheless very successful: a national response to violence and injuries, embodied in two policy documents, *Injury prevention for Canadians: Essential elements for an effective programme* (7) and *Developing an integrated Canadian injury prevention*

strategy (8), was developed first and subsequently adapted to subnational settings. Examples of policy documents developed for three Canadian provinces are as follows:

- *Developing a provincial injury prevention strategy. Strengthening Manitoba* (9);
- *Nova Scotia injury prevention strategy: report and recommendations* (10);
- *Alberta Injury Control Strategy* (11).

More recently, a number of low- and middle-income countries have engaged in national injury and violence prevention efforts. However, as yet there is little information about the impact of national policies on the number or consequences of unintentional and intentional injuries in low- and middle-income settings but evaluations to determine the magnitude of the benefits of these efforts are under way.

What is a policy on injury and violence prevention?

The term “policy” can be interpreted in a variety of ways (see **Box 1**). It is generally interpreted as being *a written document that provides the basis for action to be taken jointly by the government and its nongovernmental partners*. The intention of such a document is to raise awareness and create mutual understanding about a situation (based on an analysis of the problems, trends, causes and potential solutions); to articulate ethical and other principles that should justify and guide action; to generate a consensus vision on the actions to be undertaken; to provide a framework for action; to define institutional responsibilities and mechanisms of coordination; and to engage a variety of partners.

Other words are sometimes used to designate a policy document, such as “policy framework”, “strategy”, “strategic plan”, “plan”, “action plan” or even “programme”, but their use does not necessarily reflect differences in intention or content. Matters are further complicated by the fact that, in many languages, the precise term “policy” does not exist. Often the same word is used to designate politics and policies, which may be awkward and another reason for preferring a more neutral term such as “strategy” or “plan of action”.

Box 1.

What is a policy? Some definitions

A written expression of goals for improving the health situation, the priorities among these goals, and the main directions for attaining them (12).

A statement or expression of goals or principles of action to improve the health situation (13).

Policy is a set of principles guiding decision-making. It provides a framework against which proposals or activities can be tested or measured (14).

A set of decisions or commitments to pursue courses of action aimed at achieving defined goals of improving health. Policies usually state or imply the values that underpin the policy position. They may also specify the source of funding that can be applied to planning and implementation of policy and to relevant institutions to be involved in this process (15).

For the purpose of these guidelines, we have adopted the following definition:

A policy on violence and injury prevention is a document that sets out the main principles and defines goals, objectives, prioritized actions and coordination mechanisms, for preventing intentional and unintentional injuries and reducing their health consequences.

Usually the term “strategy” is reserved for the “how” of a policy, i.e. a strategy defines the main directions and actions required to achieve policy objectives, whereas “action plans” or “programmes” are yet more prescriptive and not only define the expected timelines, specific activities and resources needed, but also provide guidance on how to implement, monitor and evaluate activities.

Classification of injuries

For the purposes of quantifying the burden of injury and identifying intervention opportunities, it is probably most convenient to classify injuries according to their cause, i.e. as intentional (deliberately inflicted) or unintentional injuries.

Intentional injuries can be subdivided according to the people involved in the event:

- self-inflicted violence (i.e. suicide, attempted suicide, self-abuse);
- interpersonal violence (fatal or non-fatal injuries inflicted by one person against another, e.g. homicide, violence between intimate partners, sexual violence, child abuse and neglect, abuse of the elderly);
- collective violence (i.e. due to war or civil insurrection, acts of terrorism, gangs).

Unintentional injuries on the other hand are usually subdivided by their causal mechanism (i.e. how they occurred). The most commonly used subcategories for unintentional injuries are thus road traffic injuries, falls, burns and scalds, drowning, poisonings, and stabs/cut.

Both intentional and unintentional injuries can also be categorized according to the place where they occurred, i.e. on the road, at home, at a leisure/sport facility, at school or in the workplace, or according to the circumstances in which they occurred, e.g. during working hours (occupational injury) or during leisure time. When analysing injury patterns, it is often helpful to breakdown injury prevalence by population subgroup, in particular, by sex and age. Certain types of injury have been found to be especially prevalent in selected subgroups, notably children, youth, the elderly and some minority groups.

Throughout this document the term “injury and violence prevention” is used to refer to both intentional injuries (i.e. those caused by violence) and all unintentional injuries. The word “prevention” is employed in its broadest meaning, encompassing the prevention of an incident by acting on its causes, the prevention of the immediate consequences of an injurious event by designing and implementing protective mechanisms, and the prevention of avoidable death, disability and other consequences through the provision of adequate care and rehabilitation services.

How does policy relate to legislation?

Policy and legislation are intimately linked in a number of ways. Policy can be translated into legislation or ratified to become part of the legislative framework (see **Box 2**). Alternatively, new laws can be introduced, which include an obligation to formulate policy and establish a national system for injury and violence prevention (with funding sources). Developing the policy thus becomes the second step. A third option, and perhaps the most widely adopted approach, is to draft specific legislation as part of the process of policy implementation.

The important difference between the two is that whereas policy is not usually a legally binding document, legislation or laws are, and, moreover, are enacted by a law-making body. Legislation is often formulated to protect individuals or groups, prohibit certain acts, grant certain rights or attribute responsibilities. Legislation is often driven by a particular issue or problem (e.g. road safety, alcohol consumption) and becomes integral to the implementation of a policy.

Voluntary standards and some codes of practice¹ fall in between policy and legislation in that they are not necessarily binding nationwide, but they can be binding within a certain jurisdiction or for a specific setting, such as a business or professional community. For example, institutions (such as ministries, clinics and hospitals) and professional agencies (such as medical associations) have the power to write rules which, although not binding for the general population, can have punitive repercussions for their own members. With regard to injury prevention, a failure to comply with voluntary product safety standards or industry codes of practice is taken, in some jurisdictions, to be negligent, and redress can be sought in civil, and sometimes, administrative law.

Box 2

A legislative approach to propel action on violence prevention in Germany

In 1999, the Action Plan of the Federal Government to Combat Violence against Women was created by a cabinet decision. The Action Plan required all federal ministries to review all regulatory instruments for protecting women from violence under their jurisdiction (including laws and international treaties), to identify gaps in the system, and to install reforms that would fill those gaps. For example, the Action Plan called for a new civil court procedure that would allow the civil and family courts to remove an abuser from the home for periods of up to several months. This resulted in the passage of the Violence Protection Act which came into force in January 2002. Within months, most states quickly reformed their own statutes or administrative rules governing the police's responsibility to remove an abuser from the home. This was considered essential to enable a woman to seek civil court protection under the terms of the new federal Violence Protection Act.

Initially, some state-level responses to the federal government's Action Plan were ambivalent, possibly because the states had not been fully consulted during the Plan's development phase. In particular, a number of states queried whether state and community-level efforts to combat violence against women were sufficiently recognized. The federal government subsequently took advantage of a procedural mechanism normally reserved for national legislation, and submitted the Action Plan to both houses of parliament, which in Germany includes the state cabinets, for debate. The result was an endorsement from the federal law-making body, in effect a national consensus, which laid the foundation for greater coordination of federal-, state- and

¹ A code of practice is a system of rules and principles that has been accepted by a society or group of people.

community-level action on violence prevention than otherwise might have been achieved had the Action Plan not been subject to parliamentary debate. Thus, while the Action Plan was formulated as a policy, in practice, and in order to obtain the national consensus needed for implementation, it was treated as a piece of draft legislation and this ultimately led to a reform of the laws governing an individual's rights to seek protection from violence. It has also allowed for greater involvement of all ministries in the issue of violence against women, which prior to 1999, had largely been the remit of Ministries of Justice and Family Affairs. Another longer-term benefit, has been the forging of new partnerships between all levels of government, from the national government down to the community level, and also between government and various NGOs.

The role of international agreements

International declarations and platforms for action, for example, the International Conference on Population and Development, the Beijing Platform of Action and the United Nations Convention on the Rights of the Child, can have important implications for domestic injury and violence prevention efforts. In many ways, such consensus-building documents can be considered to be policy documents, and by signing up to these agreements, countries have indicated their willingness to abide by their principles. Indeed, many norms and standards enshrined in international agreements and declarations reflect principles that are binding in customary international law.

Some countries have used the international policy environment and international law as a means of providing the necessary impetus for developing national policy. The signing and ratification of an international treaty or convention provides a legal framework which can be applied at the national level by governments to increase accountability, develop policy, bring about legislative reform and ultimately create a supportive environment for violence and injury prevention. International agreements have also been used by civil societies to advocate for law reform in their own countries (see **Box 3**).

Box 3

International agreements can help civil societies to demand changes

The United Nations International Conference on Population and Development was held in September 1994 in Cairo, Egypt. This conference reached an international consensus on the importance of gender equality. Nicaragua was one of many countries that signed the final declaration.

In the wake of the conference, a number of Latin American women's associations and other NGOs formed a network to scrutinize how well their countries were doing in terms of fulfilling their newly-made commitments on gender equality. In the case of Nicaragua, a national NGO used the attention created by the conference to raise awareness about the levels of violence experienced by women, pointing out the commitments their country had recently made. Through a strong programme of advocacy, targeted largely at parliamentarians, the NGO was able to draw attention to the lack of protection for women and requested the introduction of laws to protect women against violence. A set of laws was duly promulgated by 2000. Since then, the NGO has continued to campaign for proper enforcement of legislation, denouncing abuses of the legal system and the lack of respect for national legislation.

The World Health Assembly resolutions, and also resolutions adopted by WHO regional committees, are further examples of international agreements that can be used by policy entrepreneurs² and policy-makers as a basis for obtaining political support to develop national policies. In this particular case, the international policy environment has direct relevance for ministries of health, who by adopting WHA resolutions undertake to support the principles enshrined in them. Among recent WHA resolutions, resolutions WHA56.24 and WHA57.10 on violence and road traffic injuries, respectively, address two important causes of injury (see Annex 2).

Table I lists a number of examples of international, regional and national level policy documents and legal instruments that are relevant to injury and violence prevention efforts. The list makes no pretence at completeness, but is provided to reflect the range of documents and mechanisms that can be used to guide and shape the process of developing policy for injury and violence prevention at the national level.

² *Persons or interest groups who devote themselves to pushing for the development of a policy and its implementation*

TABLE I

Selected policy documents and legal instruments of relevance to violence and injury prevention

Scope	Policy-related documents	Legal instruments
International	<p><i>Consensus-building documents</i></p> <p>Resolutions</p> <ul style="list-style-type: none"> World Health Assembly resolutions (e.g. WHA50.19, WHA57.10) United Nations General Assembly Resolutions (A/RES/58/289; A/60/5) <p>United Nations declarations and platforms of action</p> <ul style="list-style-type: none"> International Conference on Population and Development Special Session on Children <p>International technical standards</p> <ul style="list-style-type: none"> ISO/CEN* standards 	<p><i>Treaties</i></p> <ul style="list-style-type: none"> International human rights treaties International Covenant on Civil and Political Rights <p><i>Conventions</i></p> <ul style="list-style-type: none"> 1949 Geneva Convention and the 1977 Protocols Convention on the Rights of the Child (1989) The Convention on the Prevention and Punishment of the Crime of Genocide (1948) The Convention on the Elimination of All Forms of Racial Discrimination (1965) The Convention on the Elimination of All Forms of Discrimination against Women (1979) United Nations Convention on Road Signs and Signals (1968)
Regional	<p><i>Multinational consensus documents</i></p> <ul style="list-style-type: none"> European Parliament Zero Tolerance Decision (1997) European Daphne programmes to combat violence against children, young people and women and to protect victims and groups at risk (2000; 2004) Papers and resolutions of the WHO regional committees 	<p><i>Treaties and conventions</i></p> <ul style="list-style-type: none"> African Charter on the Rights and Welfare of Child (1990) African Charter on Human and Peoples' Rights (1981) Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (1994) <p><i>Multinational legislation (European Union)</i></p> <ul style="list-style-type: none"> European new vehicle safety standard directive European consumer protection directives European equal treatment and antidiscrimination directives
National	<p><i>Policies</i></p> <ul style="list-style-type: none"> National health policies National youth advancement policies National codes on non-discrimination in advertising (as a rule formulated as recommendations) <p><i>Plans and programmes</i></p> <ul style="list-style-type: none"> National road safety plans National action plans and strategies to prevent violence National family services and child care programmes 	<p><i>National laws, codes of practice and regulations</i></p> <ul style="list-style-type: none"> Professional ethics and codes of conduct Product safety standards Housing safety codes Motor vehicle safety standards Medical procedure and medical product standards Youth employment protection codes National industrial safety regulations, worker's compensation laws National road safety legislation (speed limits, use of safety equipment, drink driving regulations, driver requirement, technical requirement for vehicles) National laws on mandatory data reporting Violence protection acts, civil and criminal law statutes and procedures, mandatory youth services procedures Court-mandated treatment for child abuse/intimate partner abuse offenders

* ISO, International Organization for Standardization; CEN, Comité Européen de Normalisation [European Committee for Standardization]

What should be the role of the health sector?

In many settings, the health sector sees its primary responsibility as being the provision of care to victims of violence and injury, and does not necessarily consider injury prevention to be part of its remit. Indeed, given that the health ministry is but one of many bodies with a vested interest in injuries and injury prevention, it is not essential that it take the lead role in pushing for and shaping policies to prevent injury and violence. The impetus may well come from another source, for example, the ministry of transport (in the case of road traffic injuries) or the ministry of family affairs (should domestic violence be a primary concern). Thus depending on national circumstances and the nature of the injury problems to be addressed, the role of the health sector in the policy development process can take various forms, as follows:

- *a leadership role.* The health ministry could undertake an initial situation assessment, raise awareness among its partners in government, advocate for and create political commitment to the policy development process, and set up a multisectoral mechanism for drafting a policy.
- *a catalytic role.* The ministry of health could start and fuel the policy debate based on data from a range of sectors and provide evidence on what should be done (research and data collection). This is consistent with resolution WHA56.24 (see Annex 2), which encourages health ministries to prepare national reports on the extent of injury problems. Another ministry could then take on the leadership role.
- *a coordinating role.* The main function of the ministry of health might be to overcome institutional barriers between sectors and to engender a collaborative atmosphere.
- *a supportive role.* Improving and sharing hospital-based data to facilitate monitoring and evaluation activities, as well as serving research needs, is likely to be an area in which the health sector has its highest leverage. The role of the health system could thus be to provide data on health outcomes and effective interventions on an ongoing basis. In addition, the ministry of health could take responsibility for analysing the impact of other public policies on the prevalence of violence and injury.

When it comes to developing responses to injury and violence, there are, however, a number of specific tasks and functions that the health sector is especially well equipped to perform and for which the ministry of health should, ideally, take prime responsibility, aside from the question of basic health-care provision. These are included in the list of core tasks given in **Box 4**. The importance of the surveillance role is highlighted in **Box 5**, which describes how data on road traffic injuries gathered by the Brazilian Ministry of Health and then passed to the Ministry of Transport was instrumental in the decision to strengthen the legislation governing driving and traffic administration. In many settings, the support and participation of the health sector is likely to be critical to the success of any information, education and communication activities, especially those aimed at the general public. The involvement of the health sector in the design and implementation

of activities of this kind is thus included in the list of recommended additional tasks (see **Box 4**).

Box 4

Violence and injury prevention: the role of the health sector

Core tasks

- Develop a surveillance system to capture incidence and prevalence of injuries;
- Collect, analyse and disseminate data on the magnitude and health consequences of violence and injuries;
- Advocate for action to prevent and control violence and injuries;
- Contribute to policy development on violence and injury prevention;
- Make available the preventive services that are based in the health sector;
- Provide pre-hospital emergency care in coordination with the police and other emergency services;
- Provide emergency care for the injured in health facilities;
- Provide rehabilitation services for those who have been injured;
- Evaluate intervention activities related to violence and injury prevention using a science-based approach;
- Support and/or provide facilities for forensic assessment, in particular, in cases of sexual violence;
- Train public health and health-care providers in injury prevention and care.

Additional tasks

- Collect data on risk and protective factors;
- Design and implement information, education and communication activities to prevent violence and injuries;
- Lead policy development;
- Ensure leadership and coordination;
- Advocate for changes to existing legislation;
- Recommend new regulations;
- Perform research.

Box 5

The role of the Brazilian Ministry of Health in documenting road traffic injuries

Injuries, mostly due to violence and road traffic crashes, are a leading cause of death in Brazil, second only to cardiovascular diseases. According to data from the Ministry of Health's Mortality Information System (SIM) for period 1991–2001, the number of deaths due to road traffic crashes increased dramatically between 1991 and 1997, reaching a peak of 35 756 deaths in 1997. Between 1998 and 2001, however, there was a marked reduction in road traffic injury mortality. The mortality rate reduction was most significant in the state capitals and in the south-east region of the country. The observed decrease in deaths coincided with the introduction of the New Transit Code at the beginning of 1998. The New Transit Code, a piece of legislation aimed at drivers, not only created more severe punishment for driver infractions but also transferred the responsibility for traffic administration to the local level.

Policy options: general considerations

There are several ways to address the issue of violence and injury prevention in a coherent manner at the national level. The route taken will depend on a number of factors, including the prevailing political environment, the prevalence of various types of injuries in different population groups, age groups and locations, the availability of resources, and the nature of existing policies, strategies and programmes.

If political leaders are already aware that injuries and violence represent a serious public health problem — and the policy environment is favourable — then the time is ripe for creating a comprehensive national policy on violence and injury prevention. Under such circumstances, the process of developing a national policy will go a long way towards forging a common vision among stakeholders, fostering coherence and coordination between partners, raising political commitment and facilitating the allocation of resources.

Generating interest and demand

If the political environment does not (yet) favour policy development, it will be necessary to first increase public support for violence and injury prevention. This can be done by gathering and disseminating data on the impact of injuries and by demonstrating that appropriate action can reduce the problem. Using the mass media to publicize stories of individuals and families who have been affected by injuries is often a good way to raise public awareness about the issues at stake. The testing of potential interventions for some of the more visible injuries in small pilot projects can also help to provide the necessary momentum for policy development. If successful, demonstration projects can be used to draw attention to the problem, show that something can be done and in turn become the starting point for a wider debate. Small-scale projects have preceded policy development in a number of countries, for example in Viet Nam, where the implementation, over a five-year period, of a community-based pilot project provided the trigger for a nationwide injury prevention effort (see **Box 6**).

Box 6

Developing a national policy on accident and injury prevention in Viet Nam

Over the last 10 years, injuries have become one of the leading causes of death in Viet Nam, and now are responsible for three times as many deaths as communicable diseases. For every person killed, two more are permanently disabled. The most significant causes of injury deaths are road traffic crashes, drownings and falls, the highest burden being born by children aged 5–9 years.

With the support of the Swedish International Development Agency, the Injury Prevention and Safe Community Programme was started in two communes of a Hanoi suburb in 1996. Starting at the communal level, the programme was progressively scaled up, first to the district level and subsequently to the provincial level, and in 1998 was further expanded to cover six more provinces and cities. Surveillance data for 6 districts revealed considerable reductions in the number of injury cases; in Cam Pha commune, Quang Ninh province, for example, injury cases were reduced by 29% from 3237 cases in 1997 to 2295 cases in 2001, and in Thinh Liet commune, Tu Liem district, Hanoi the number of cases of injuries dropped from 302 in 1996 to just 25 in 2001.

Following the success of the intervention programme, and taking into account the views of other ministries, public sectors and also NGOs, the Ministry of Health developed a national

policy on injury prevention for the period of 2002–2010 (16). It was issued in December 2001 and formed the basis of a subsequent action plan, split over two periods, 2002–2005 and 2006–2010 (17). The injury types targeted by the action plan include road traffic injuries, childhood injuries (especially drowning, burning and poisoning), injuries in the home, and occupational injuries (in particular, falls and electrocutions).

Policy entrepreneurs are often essential to starting and sustaining a policy development process that leads to social change (see **Box 7**). Although they are usually committed to a specific aspect of injury prevention, policy entrepreneurs are also adept at seeing the bigger picture and are able to identify the strategic steps needed to engage all partners in the policy development process. No one group typifies the policy entrepreneur; they can come from a wide range of different areas and backgrounds, such as the health professions, academia, government departments, as well as NGOs. In the example situation described in **Box 7**, the driving force behind the development and implementation of law and institutional change to prevent violence against women was provided by women's advocates.

Box 7

Women's advocates drive law reform in Austria

The Austrian Violence Prevention Act came into effect in the late 1990s; its main focus is on intimate partner violence. Women's advocates and the Ministries of the Interior and for Women's Affairs were jointly responsible for drafting the Act. The collaborative effort between these partners extended to the creation of a public-private advocacy structure (in the form of intervention centres) and, through problem-awareness raising and continuing education, in particular among the police, to the paving of the way for the implementation of the new law. The drafting and subsequent implementation of the Violence Prevention Act, especially during the early phases, is possibly the first successful example of collaboration between women's advocates and a European government – at least in terms of developing a gender-sensitive law. Continuous grass roots monitoring and evaluation of the implementation of the law has since contributed to a very forceful debate, both in Austria and elsewhere in Europe. Conferences on lessons learned and first-hand experience of the Austrian model have helped to convince policy-makers in other countries, including the heads of several European governments, of the benefits of the approach. This in turn has propelled joint efforts to combat partner violence between community-based advocacy groups, governments and parliaments, resulting in new protection mechanisms, law and institutional reform in several other European countries.

Scope of injury and violence prevention policies

At some point in the policy development process, the relative merits of a single document covering all aspects of violence and injuries prevention will need to be weighed up against those of developing more specific policies, typically policies that address only one type of injury. Those advocating for separate policies by injury type argue that each type has distinct characteristics and therefore needs a specific approach. Furthermore, in most countries different groups of organizations and experts are interested in different injury types. It is also argued that the more focused the policy, the faster its implementation and impact will be; this can be a persuasive factor for politicians and other decision-makers who need to show rapid progress once a policy has been agreed upon. Others highlight the potential advantages of a policy that addresses both violence and

unintentional injuries, pointing out the mutually beneficial aspects of a combined response (see also **Box 8**).

Box 8

The benefits of developing a single policy for tackling the problems posed by unintentional injuries and violence in WHO European Region

Injuries are the third largest cause of death in the WHO European Region, second only to cardiovascular disease and cancer. The burden is greatest among the economically and the socially marginalized groups, and in children and young people. The need for a public health approach to injury, which recognizes safety as a priority area in health and social policy, was highlighted at the Fifty-fifth session of the WHO Regional Committee for Europe (18). Delegates endorsed the view that an important strategic step towards achieving this goal is the development of a combined policy response for violence and unintentional injuries. The reasons given for addressing violence together with unintentional injuries are as follows:

- the greater potential for advocacy;
- the opportunity to build on the synergy derived from common approaches to hospital surveillance and community surveys;
- the fact that violence and unintentional injuries have the same underlying determinants (i.e. economic, social, political and environmental) and risk factors (e.g. alcohol, drugs), which disproportionately affect vulnerable groups in the population;
- the same multisectoral approach is required to develop programmes to deal with common risk factors, such as alcohol abuse (this is a leading risk factor for the whole spectrum of unintentional injuries and violence);
- the public health approach with evidence-based interventions and evaluation is common to both;
- the fact that both demand that ethical considerations such as social justice and equity be taken into account when considering vulnerable populations;
- irrespective of the cause of the injury, the same provider is usually involved in health service responses to victims, for example emergency pre-hospital and trauma care, toxicology care for poisonings. Similarly, support services such as those for post-traumatic stress disorders and rehabilitation, as well as the organization of emergency services and the development of institutional and technical capacity are shared.

Some countries have taken the option to start with a holistic approach to injury prevention, i.e. one that encompasses all intentional or unintentional injuries. Examples include Australia (19), Brazil (20) and Viet Nam (16). Others have chosen to address specific injury problems. The areas most often selected by countries for individual attention are road traffic injuries and road safety, domestic violence, violence against women, protection of children and youth against sexualized violence and exploitation, self-inflicted injuries/suicide, and social or ethnic violence (see Annex 1). Addressing injury problems in separate policies does not necessarily preclude the development of an overarching policy on injuries and violence prevention. Indeed, for some countries, a piecemeal approach to policy development—whereby the most urgent or the most visible injury problem, or the one for which solutions are most readily available is addressed first—will be a more realistic strategy. A country may, for instance, decide to start by developing a policy for reducing road traffic injuries, and follow this at a later date with a policy on youth violence.

Mainstreaming injury and violence prevention into existing policy and legislation

Instead of developing a policy that stands on its own, it may be easier to integrate certain elements of an injury prevention policy into existing national policies and/or legislation that address related issues. For example, it might be possible to seek better protection of pedestrians through improved traffic legislation; to incorporate aspects of child safety into national environmental health action programmes; to include gender-based violence in strategies to improve adolescent health; to address violence against women and prevention and treatment of sexual abuse in an existing policy on reproductive health; to protect youth from exploitation and neglect by ensuring this be taken into account in a national youth policy; or to consider injuries as part of national policy for mental health. Issues related to violence and injury prevention can also be mainstreamed into some of the broad-based global development frameworks, including the Millennium Development Goals, Poverty Reduction Strategy Papers, United Nations Development Assistance Frameworks (UNDAF), Health Sector Reform and the Stability Pact for South Eastern Europe.

The strength of this option is that violence and injury prevention will be addressed and political awareness raised even if it is not a high priority for politicians and policy-makers. Its limitation is that efforts to prevent violence and injuries may remain fragmented, underresourced and uncoordinated. In some settings, in particular, where the policy environment is not yet receptive to developing a national policy on a specific injury topic or the issue is socially sensitive, mainstreaming some aspects of violence and injury prevention into an existing policy may be the only sensible option. Adopting such a strategy to tackle the matter of violence against women has produced positive results in several countries, for example, in Yemen (see **Box 9**).

Box 9

Yemen: the role of the Women's National Committee

Even at the end of the 20th century, mere mention of the words "violence against women" was strictly taboo in Yemeni society. Tacit social acceptance of violence against women meant that little was done to tackle problems of this nature. However, in 1996, and in response to increasing demand from women's groups and associations, the government of the Republic of Yemen created the Women's National Committee (WNC). Initially, this committee concentrated its efforts on the issue of female genital mutilation (FGM), and in time two conferences on this subject were held in Aden. Later the WNC added opposition to early marriage to its list of operational objectives, considering this to be another form of violence against women. This subject was subsequently introduced as a priority within the national social gender strategy. Since the late 1990s, owing partly to the efforts of the WNC, Yemeni society has gradually acknowledged violence against women as a social evil. This acceptance allowed the WNC to organize the first national conference on violence against women in March 2004. The conference was held under the auspices of the Yemeni Prime Minister and tackled issues such as society violence and female education, early marriage in Yemeni society, family violence against women, and Islam and eliminating violence against women. Through this conference, the WNC had hoped to highlight the fact that Islamic law can be used to prevent violence against women, and has since become an important partner in the process to develop a national policy on violence prevention and control.

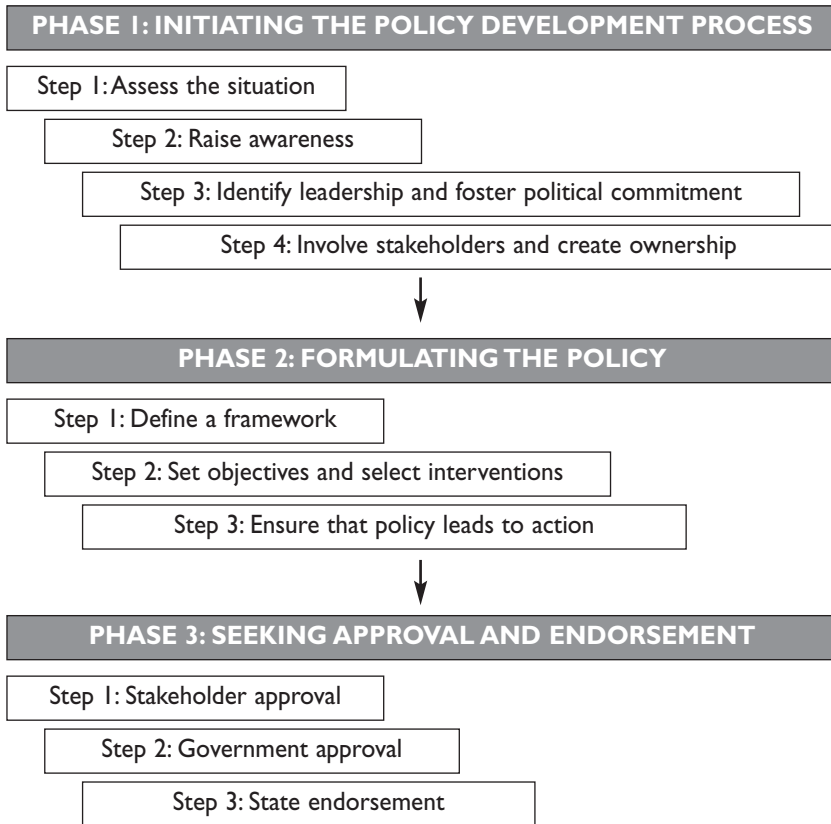
Part II. Developing a policy response to injury and violence

These guidelines recommend that policy development be executed in three phases. In phase 1 the policy development process is initiated and the respective roles of the main stakeholders identified. Drafting of the policy document itself takes place during phase 2, after which, in phase 3, official approval and endorsement of the policy is sought. Each of these three principal tasks can be broken down into a series of steps; these are summarized in **Figure 1**, and described in greater detail in the next few pages.

It is difficult to specify a timeframe for any particular phase or step of the policy development process, as this will depend very much on the prevailing conditions in any given country. In practice, it is likely that there will be some overlap between the individual steps; for instance, some of the activities started during phase 1 will continue throughout the lifetime of the policy development process, and even beyond.

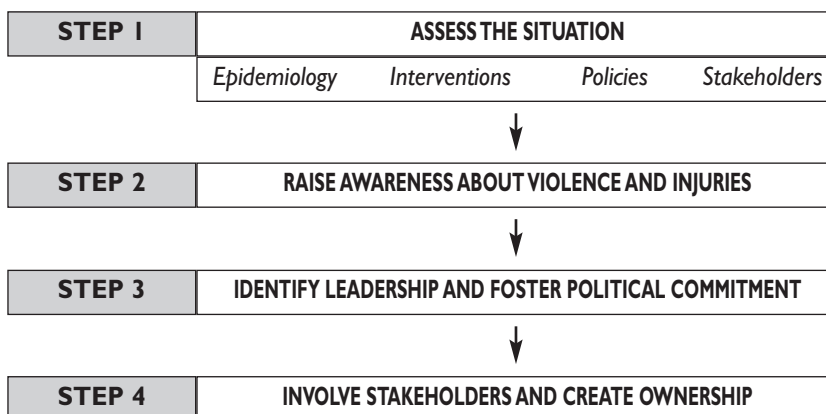
One should keep in mind that sometimes the very act of developing a policy document can bring about significant changes in attitudes and perceptions that can go a long way towards tackling a problem. Experience has repeatedly shown that the lead up to the preparation of a policy document not only creates an environment that is supportive of violence and injury prevention but also engenders a commitment from interested parties to take action. In the long term, this change may be as important an outcome as the policy document itself.

Figure 1

The three phases of the policy development process**Phase 1: Initiating the policy development process**

Getting the policy development process off the ground usually requires four things — an assessment of the current situation, a high level of awareness of the issues, a strong sense of leadership and political commitment, and the involvement of all key stakeholders (see **Figure 2**). Securing these four things represents the first steps in the policy-making process and can either be undertaken consecutively or in parallel, depending on the circumstances of individual countries. In fact, in practice several activities run well in tandem, for instance, the act of carrying out a situation assessment very often simultaneously does the job of raising awareness and arousing political interest.

Figure 2

Initiating the policy development process: the individual steps**Step 1: Assess the situation**

Without a good understanding of the extent and causes of injury, a reasonable knowledge of existing policies, laws and regulations, and a fair idea of existing and/or possible interventions, it is difficult, if not impossible, to formulate an effective policy for injury prevention. It is also helpful to identify at the outset of the policy development process all potential stakeholders. A comprehensive situation assessment should thus aim to cover all of the following:

- an epidemiological assessment;
- intervention assessment;
- assessment of the existing policy environment;
- a stakeholder analysis.

The results of the assessment will not only dictate the scope and overall direction of the policy — whether all injuries are to be tackled or just a specific type, whether a stand alone policy is going to be more effective than one which is linked to other public health plans and strategies — but are also prerequisites for phase 2 of the development process — defining the content of an injury prevention policy in terms of its goals, objectives and priority actions. Although all four assessment components are vitally important, and none should be overlooked, a balance sometimes needs to be struck between collecting enough information on the one hand and not consuming too much in the way of precious resources and time on the other. Before embarking on costly new data collection, therefore, it is advisable to review any available information and to exploit this as far as possible, but bearing in mind any shortcomings it might have.

The epidemiological assessment

In some countries, injury surveillance may already be part of the national health data collection system. If so, then data on the incidence of different types of injuries their root causes, risk and protective factors, their consequences, as well as their distribution within the population (particularly affected groups) will already be available. Elsewhere, although raw data may exist, they may not be in a useable format, in which case it will be necessary to assemble and collate relevant information from a variety of disparate sources in order to build up a picture of the injury problem. The most easily accessible and immediately relevant data sources should be tapped first; these would normally be death certificates, health clinic records, hospital in-patient records, emergency room records and police reports on road traffic injuries and violence, and any records on occupational injuries. If appropriate, data from community surveys and insurance company records (health/accident insurance, automobile insurance, workplace insurance schemes) may then provide further information. To serve the dual purpose of raising awareness about violence and injuries (see step 2), the results of data collation exercises such as this should be presented in a clear, easily understandable format (see **Box 10**).

Box 10

Making use of existing data in Mongolia

It was surgeons from the National Trauma Hospital that were initially responsible for bringing the problem of injuries to the attention of the Mongolian government. Although numerous data on injuries were available, they had not been collated and analysed in any meaningful way. This situation was rectified and in 2003 when a report titled, *Injury in Mongolia* was published. Violence, road traffic crashes, falls, child domestic injury and alcohol abuse were identified as key issues. A nascent public infrastructure, historical cultural norms and extreme winter weather were cited as possible contributory factors.

On the basis of the findings of the above-mentioned report, a national plan for injury prevention was endorsed by the Mongolian Cabinet and a cross-sectoral national committee for injury prevention established. It is hoped that improved methods of emergency department trauma surveillance will enhance the information base available to the national committee in the future.

Not all countries have sufficiently well-developed health data collection systems on which to base an epidemiological assessment. Under such circumstances, it may be necessary to carry out surveys to gather the relevant baseline data on injury prevalence and related issues. The WHO *Guidelines for conducting community surveys on injuries and violence* (21) should facilitate this process. WHO has also produced a set of guidelines on injury surveillance, which will be of interest to those seeking to establish mechanisms for the systematic collection of data on violence and injuries (22). **Box 11** relates how the results of a research project to generate context-specific data on patterns of road traffic injury deaths have been used to enhance the capability of the Fiji Ministry of Health to develop meaningful intervention strategies.

Box 11

A research project informs strategies to prevent road traffic injuries in Fiji

Despite anecdotal evidence of significant societal and economic consequences, the burden of injury in Fiji is relatively undefined and the response fragmented. In 2004, the Fiji School of Medicine and the School of Population Health at the University of Auckland, New Zealand, commenced a three-year research programme to address these issues. Specific projects and activities undertaken as part of the Traffic-Related Injury in the Pacific (TRIP) programme include situational analyses of the burden of injury, establishment of population-based trauma registers and a series of epidemiological studies on road-user injuries. The latter comprise cross-sectional surveys designed to estimate the prevalence of factors associated with road crashes and case-control analyses aimed at identifying priorities for intervention by quantifying the contribution of potentially modifiable factors.

An important aspect of this programme is its partnership with the Fiji Ministry of Health. Shortly after its commencement, two of the programme's lead researchers were appointed as co-chairs of the newly established National Accident and Injury Prevention Sub-committee, which comes under the umbrella of the National Non-Communicable Diseases Committee chaired by the Minister of Health. The subcommittee has representatives from several government agencies and a broad range of stakeholder and community groups, and is responsible for implementing the accident and injury component of the Fiji National Non-Communicable Diseases Strategic Plan 2004–2008. Acting through the National Non-Communicable Diseases Committee, the subcommittee is thus in a position to guide government policy on injury prevention and recommend priorities for action.

Intervention assessment

In order to obtain a clear view of the range of the existing and potential interventions which prevent injuries from occurring, or which reduce their harmful consequences, it is necessary to ask the following set of questions.

- What is already being undertaken in the country?
- What is known about possible interventions to address the problem?
- Which interventions have been tested in the country or elsewhere?
- What is their potential effectiveness based on the latest international and national research results?
- Are they relevant for this specific setting or can culturally-appropriate modifications be proposed?
- What are the important gaps in current knowledge?
- Is the government already allocating resources to violence and injury prevention?
- Who else is devoting resources?
- Which NGOs or other private entities are involved in activities to prevent injuries?
- Are there university or research institutes that have worked to raise the profile of the injury burden or evaluated potential solutions?

Assessment of the existing policy environment

An assessment of the current policy environment is necessary to determine the direction of future policies. Existing national health policies, laws, decrees and regulations should thus be reviewed in the context of injury prevention and any gaps identified. Looking at how current policies are being implemented and whether or not regulations are being enforced are integral parts of this exercise. For example, most countries already have some form of policy or legislation for dealing with road safety issues. If, however, the number of road traffic crashes or deaths remains high despite the existence of road safety policies and laws, this would be a fair indication that the policy is not working or that the enforcement of regulations is inadequate.

The review should also consider the country's constitution and any relevant international conventions, agreements or treaties that have been signed by the country. It is likely that the ministry of health is a signatory to the World Health Assembly resolutions on violence and health and global road safety. Finally, a policy environment assessment needs to examine current policy-making mechanisms. How, for example, have policies in other areas been formulated? How does a policy become officially adopted by the government? What role do the judiciary and legislative systems have in policy approval, and ensuring its implementation? What are the endorsement mechanisms?

Stakeholder analysis

A stakeholder analysis sheds light on the social environment in which the policy will be developed and implemented. Its primary function is to identify all possible partners who might have an interest in addressing an injury problem, including those who might initially oppose efforts to prevent violence and injuries. Potential stakeholders include government departments, NGOs and institutions that will be affected (positively or negatively) by the policy, local communities, formal or informal groups, as well as individuals (e.g. representatives of work forces, victims of injuries). Stakeholders might also include manufacturers of goods and equipment that would be affected by the policy and any associated regulations, regulators, industry bodies and associations, importers and exporters (see **Box 12**).

Box 12

Potential stakeholders in the development of policies for violence and injury prevention*State and government*

- Elected officials (i.e. members of parliament)
- High-level policy-makers (e.g. King, Queen, President of the Republic, First Lady, Prime Minister)
- Ministries and related departments
- Institutions, institutes, agencies and centres (e.g. financial institutions, public health institutes, institutes for social marketing, national institutes for women, national poisons information centres)
- Committees, councils, commissions, liaison groups
- Professional key gatekeepers (e.g. health-care providers, school staff, administrators, police officers, swimming-pool staff)
- Regional and local governments
- Monitoring agencies (e.g. statistics bureau, public health institutes, centres against violence)

Academics

- Universities and related faculties and departments
- Research institutes
- Think tanks

Non governmental entities/non-profit entities (civil society)

- Associations (e.g. professional, parent-teacher, transport-related), colleges (e.g. colleges of trauma surgeons)
- National and international organizations (e.g. NGOs, community), societies (e.g. Red Cross), federations, United Nations organizations
- Advocacy groups (e.g. victim associations, victim care groups, speak out and consumer groups)
- Community groups and individuals (e.g. women's, cultural and religious groups, health committees, traditional leaders)
- Volunteer groups (e.g. nursing home volunteers, first-aid providers, coast guards)
- Sponsors (e.g. bilateral donors, international foundations, clubs)

Private for-profit entities

- Media outlets (e.g. print, television, radio, Internet)
- Professional key gatekeepers (e.g. traditional healers, labour associations, trade unions, medical associations)
- Manufacturers of good and equipment
- Importers and exporters
- Insurance industry

The second important function of the analysis is to examine the remit of each stakeholder and to understand the relationships between them. A careful analysis should be made of the position and mindset of all major stakeholders as this will facilitate the design of appropriate approaches for involving them. It is especially important to identify supporters and opponents and, moreover, to appreciate the reasons for their respective positions so as to be able to develop a marketable package that satisfies all parties concerned.

Public opinion (print, media, and public statements) can be a strong driving force, and is another factor to consider when charting the potential influence of the likely players in the policy development process.

With these comments in mind, the key objectives of a stakeholder analysis are thus:

1. To identify key stakeholders, define their characteristics and examine how they will be affected by the policy (e.g. their specific interests, likely expectations in terms of benefits, changes and adverse outcomes).
2. To assess their potential influence on the development, approval and implementation of the policy.
3. To understand the relationship between stakeholders and possible conflicts of interest that may arise.
4. To assess the capacity of different stakeholders to participate in policy development and the likelihood of their contributing to the process.
5. To decide how they should be involved in the process to ensure the best possible quality and viability of the policy, in particular:
 - the nature of their participation (e.g. as advisers or consultants, or as collaborating partners);
 - the form of their participation (i.e. as a member of a task force, advisory group, steering committee or sponsor);
 - the mode of their participation (e.g. as an individual participant or as a representative of a group).

Step 2: Raise awareness about violence and injuries

The decision by government to embark on policy development usually stems from an advocacy and communication process. Pressure to act can come from specific groups (e.g. burns surgeons, women's associations, victims' associations), from external factors (i.e. international pressure, World Health Assembly resolutions, other international agreements, international/regional declarations), from high-profile politicians or individuals (e.g. a First Lady, members of a royal family), and/or from events which mobilize the public interest (e.g. tragic cases of child abuse, serious road traffic accidents, chemical disasters). The latter was a significant factor in Thailand where a well-timed media campaign, which highlighted recent increases in the number of road traffic deaths, raised enough public concern about the issue to overcome the inertia of the bureaucratic system and to push for effective action (see **Box 13**).

Box 13

Raising awareness about road traffic injuries in Thailand

Between 1984 and 2002, the rate of road traffic injuries increased dramatically in Thailand. There was a particularly strong peak between 1994 and 1996, which coincided with a time of high economic growth (the so-called “bubble” economy) and a rapid rise in the number of motor vehicles (between 1994 and 2000 the number of vehicles almost doubled). Traffic crashes became the second leading cause of disability-adjusted life years (DALYs) lost in men, and the fifth in women. Between 70% and 80% of the crashes involved motorcyclists, and more than 70% of injuries were head injuries.

During the 1990s, several action plans to reduce road traffic injuries were implemented and re-launched, but with little or no effect. These repeated failures were attributed to a number of factors:

- a lack of clarity and comprehensiveness of the safety measures;
- a lack of continuity in implementing the plans;
- inadequate financial support;
- an overemphasis on discipline (i.e. punitive measures);
- the lack of transparency of the organizational set-up;
- considerable duplication of effort and a lack of coordination.

Starting in 2001, extensive media coverage of the seriousness of road traffic crashes during two consecutive major festival periods led to a turning point in the battle to reduce road traffic deaths. This media campaign, which was based on hospital data, simultaneously turned the tide of public opinion and prompted the government to adopt a more coherent policy response. For the 2003 new year celebrations, the government launched its new drive to curb road traffic crashes, and backed this with a strong law enforcement effort. According to the police, about 200 000 motorists were stopped and checked during one 7-day period for compliance with helmet and seat-belt use, and driving without alcohol. In July of the same year, a national policy document, using as its theme the five Es — Enforcement, Education and participation, Engineering, Emergency services and Evaluation and monitoring — was published.

Communication and awareness-raising, along with advocacy and education, can influence public opinion, policy-makers and programme managers and thus are often vital forces for mobilizing the political commitment and resources that are needed to drive the policy development process forward. Results from step 1 (the situation assessment) should be used whenever possible to raise awareness, and, if necessary, to do more targeted lobbying, especially among key decision-makers, politicians and opinion leaders. At the same time, the general public needs to be made aware that the issue under debate is critical to their health and safety. This tends to be more effective if done in collaboration with community groups, NGOs, advocacy groups, the media, think tanks and high-level policy makers (e.g. law-makers, senators, congress representatives). Law-makers, enforcers and manufacturers are another important target group; given their general lack of direct experience of public health matters, it may be necessary to make a special effort to brief law-makers, enforcers and manufacturers about the problem of injuries and their role in bringing about possible solutions.

The success of the post-2001 campaigns in Thailand (Box 13) was attributed, at least in part, to the synchronization of the release of information with an event of high social

significance (in this case a new year festival); indeed, the timing of the media campaign was considered to be at least as important as its content. Experience elsewhere has similarly shown that releasing information and reports about injuries and related matters as part of a campaign to raise awareness is often more effective when tied to international campaigns, days or other nationally important dates. Alternatively, awareness-raising campaigns can be timed to coincide with international conferences or fora, or popular festivals or fairs. **Table 2** provides a list of days that could be used as a hook for awareness-raising campaigns by anyone wishing to communicate information about injuries and violence; in each case, the most appropriate injury topics are suggested.

Table 2

Days of potential relevance for injury and violence prevention awareness-raising campaigns

Date	Issue	Injury type
8 March	International Women's Day	Domestic violence, sexual violence, interpersonal violence
7 April	World Health Day	Violence and injuries are linked to a range of public health problems
9 May	International Mother's Day	Domestic violence, child abuse and neglect
10 May	Move for Health Day	Road traffic injuries
15 May	International Day of Families	Domestic violence, injuries in the home
25 May	Africa Day	Violence and injuries in Africa
4 June	International Day of Innocent Children Victim of Aggressions	Child abuse and neglect, domestic violence
16 June	International Day of the African Child	Injuries and violence among African children aged 0–4 years and 5–14 years
20 June	World Refugee Day	Sexual violence, interpersonal violence
26 June	International Day against Drug Abuse and Illicit Trafficking	Violence, road traffic injuries, suicide
26 June	UN International Day in Support of Victims of Torture	Collective violence
12 August	International Youth Day	Youth violence, violence at school, suicide, injuries in the home, road traffic injuries
4 September	International Day of Peace	Collective violence
1 October	International Day of Elderly	Falls, elder abuse and neglect, suicide
5 October	International Walk to School Day	Road traffic injuries
10 October	World Mental Health Day	Suicide
16 November	International Day for Tolerance	All forms of violence
19 November	World Day for Prevention of Child Abuse	Child abuse and neglect, domestic violence
18–26 November	Week for International Solidarity	Violence against women, violence against the elderly, first-aid advocacy groups
20 November	Universal Children's Day	Child abuse and neglect, domestic violence, injuries in the home, falls, drowning, burns
25 November	International Day for the Elimination of Violence against Women	Domestic violence, sexual violence, interpersonal violence
1 December	World AIDS Day	Sexual violence, emergency care, suicide
3 December	International Day of Disabled Persons	Disability and rehabilitation
10 December	Human Rights Day	Violence and injury
2nd Sunday in December	International Children's Day (with UNICEF and IATAS)	Child abuse and neglect, domestic violence

Step 3: Identify leadership and foster political commitment

To succeed, policy development requires the involvement of several government ministries, as well as the for-profit private sector, NGOs and advocacy groups, and civil society at large. Ensuring that a new policy initiative extends beyond the interests of one particular sector requires political commitment and strong leadership, ideally at the national level. It is paramount therefore that a lead agency be identified during the early stages of the policy process. Thus at this stage of the policy development process, the critical questions that need addressing are: Who should lead the process? What is the role of the leader? What is the role of the ministry of health?

The main function of the leadership or lead agency is to coordinate the input of those involved to ensure that the process moves forward. The lead agency must also be able to create and sustain a supportive environment for policy debate, bearing in mind that it may take many months to come up with a final draft of the policy that is acceptable to all. Although leadership need not necessarily rest with the same entity or person during the lifetime of the policy, any change in leadership must however be made transparent and acceptable to all stakeholders. The Austrian approach illustrates well the need for clear delineation of responsibilities; in this case, the impetus for a national injury prevention policy came from an NGO, who also played a major role in developing the policy, yet overall ownership was retained by the government (**Box 14**).

Box 14

The role of the Institute Sicher Leben, a nongovernmental organization, in the development of the Austrian national policy on injury prevention

In early 2004, the Institute Sicher Leben (ISL), an Austrian NGO concerned with safety, approached the Ministry of Health with a view to initiating a dialogue to develop a national action plan on injury prevention. The Institute proposed that the Ministry of Health take the lead role in coordinating the policy planning process, and that ISL provide technical expertise and support. Significantly, ISL did not make financial support a necessary prerequisite of its participation. The Minister of Health agreed and announced in June 2004 at the World Conference on Injury Prevention, which was held in Vienna, that Austria would shortly be starting work on the drafting of a comprehensive Action Plan on Injury Prevention. ISL duly received the contract for this task and is currently in negotiation with other stakeholders regarding the proposed action plan. It is the intention that the plan will focus on unintentional injuries in the first instance, as the Ministry of Transport has already developed a Road Safety Plan and there is a draft plan for safety at work. A violence prevention plan will be developed at a later stage.

ISL is devoting considerable effort to canvassing the opinions of high-level decision-makers from all the various government departments (i.e. the Ministries of Interior, Justice, Education and Transport), as well as enlisting the support of NGOs, practitioners and the media. In order to maximize impact at the political level, ISL has stressed throughout this process that ownership of the national action plan lies with the Ministry of Health and not with ISL. The plan itself contains a number of proposals for action at both the federal and provincial level, including changes in legislation and standards, as well as steps to integrate injury prevention into existing political structures. To ensure that the proposals are politically acceptable, expert opinion is being sought from political stakeholders from all the ministries concerned to assess their viability. This is seen as one of the crucial steps in the policy development process and one that will ensure future political support. It is intended that the plan will be presented to the Austrian Parliament in 2006 for ratification, with an announcement of its adoption during the First European Injury Prevention Conference in Vienna in 2006.

Including and coordinating the views of so many partners can be both demanding and time-consuming. Some countries have found it helpful to establish multisectoral steering committees, management boards or task forces to share the overall responsibility for policy development. Rotating the responsibility of hosting and chairing meetings can be a good way of ensuring that each stakeholder has a role — and therefore a stake — in the development process, and subsequently, in the implementation of the policy.

To work well, a multisectoral committee should have well-defined working procedures and a clear work plan for policy development, which extends to its adoption and eventual implementation. Such bodies often benefit from high-level political support (i.e. from the President, the First Lady or the Prime Minister's office). Strong political commitment to the multisectoral process has certainly been a key factor in the establishment of a national committee for road safety in the case of Yemen (see **Box 15**).

Box 15

Creation of a national committee on road safety in Yemen

In spring 2004, a heavy goods vehicle crashed into a busy street market in a small Yemeni village, injuring and killing many people. A few days later, the Yemeni press reported yet another serious road traffic incident. Taking advantage of the heightened awareness among the population of the problem of road traffic injury, and as part of events to mark World Health Day, in April the Minister of Health declared that the year 2004 would be dedicated to road safety.

A one-day workshop was organized, at which concerned ministries presented papers on what they perceived to be their role in improving road safety. As a direct result of the workshop, the Prime Minister announced the creation of a multisectoral national committee for road safety, to be led by the Ministry of Public Works. Establishing the Ministry of Public Works as the lead agency meant that petrol taxes could be used to fund some of the activities of the committee. Four other government ministers were nominated as members, among them the Minister of Health. The committee's main objective is to develop a national action plan to prevent road traffic injuries.

Step 4: Involve stakeholders and create ownership

The greater the involvement of stakeholders during the development process, the greater their sense of ownership and motivation. A failure to consult key groups might result in the policy not being taken up or even rejected (see **Boxes 16 and 17**). It is thus of utmost importance from the outset to involve all those empowered to solve the problem that the policy is seeking to address. Even seemingly minor details — such as whose logo appears on official documents — can be vital to creating a sense of ownership. If some participants are not willing or able to be involved in the policy process at the outset, rather than exclude them entirely, it is often a good idea to keep them informed about progress, in the hope they may be persuaded to rejoin at a later stage.

As many injury problems are ultimately tackled at the community level, community participation is essential to the policy development process and special effort should be made to ensure the involvement of relevant community groups. This is particularly true in settings where civil society groups, for example, professional associations, women's associations, advocacy groups, victims' associations, religious groups, local villagers and

tribal leaders, are strong advocates and social actors. Failure to take the needs and concerns of such groups into account can have disastrous consequences. For instance, in Uganda, a failure to take into account the concerns of the Muslim community has meant that the Domestic Relations Bill has still not been passed three years after it was first tabled in parliament. The proposed bill contained clauses that the Muslim community perceived as being hostile to their faith; the offending clauses gave self-determination to women, and in seeking to reduce their vulnerability in relationships, made marital rape a crime. In this case the challenge was to protect women and condemn marital rape in a way that would be acceptable to the Muslim community.

Box 16

The importance of the need to build commitment and create ownership

In 1986, an international expert was contracted as a consultant to develop a national programme on injury prevention in a specific country. At the end of an extensive situation analysis, during which more than 50 people were interviewed, a set of recommendations and an action plan for injury prevention were produced. The main recommendations were as follows:

- build strong political commitment;
- create a national multisectoral council;
- build up a reliable information system and organize research;
- integrate preventive activities into primary health care;
- organize information, education and communication campaigns;
- enforce safety measures;
- enact legislation;
- adapt the educational curriculum;
- organize an efficient emergency medical services system.

Nevertheless, throughout the 1990s, the number of injury deaths continued to rise yet no policy response was developed at national level. Eighteen years later, in 2004, WHO was invited by the same country to develop a strategy to tackle the growing problem of violence and road traffic injuries. The second situation analysis reached much the same conclusions as those of the 1986 mission, but also provided some indications as to why the recommendations made in 1986 were never followed. Firstly, despite the fact that it was considered a priority to induce a multisectoral response, the great majority of the persons contacted during the 1986 mission were from the health sector. Very few people from other sectors were interviewed. Secondly, the recommendations were not the product of a consultative mechanism that could have built consensus, ownership and commitment. Moreover, no responsibilities were attributed and no follow-up mechanisms defined.

This example reinforces the point that although a situation analysis is a prerequisite, it is not in itself sufficient to trigger the development and implementation of a national strategy. This requires a certain amount of awareness raising to sensitize potential stakeholders to the need for action to reduce the public health impact of injury and violence.

Box 17

Attempts to gain political support to improve emergency medical services in Tunisia

A national strategy to improve the quality of medical emergency services has existed in Tunisia since 1996. A political willingness to extend such services had been expressed on several occasions.

In 2000, the Tunisian Emergency Medicine Society was created. This group of committed medical practitioners took the initiative to formulate a set of recommendations, including proposals for legislation, for improving medical services at the national level. In particular, they were concerned about the need to:

- develop structured networks between the different sectors and organizations involved in emergency medicine;
- increase the coordination within existing emergency services;
- improve the quality of services and medical training.

They formed a working group that met regularly over a period of several months to draft a strategy to address the shortcomings in the current system. Once the strategy document had been finalized, it was presented to all potential partners, including political decision-makers, in the hope of engaging them in the debate and enlisting their support. However, although the recommendations of the group were well received, the group was not able to gain sufficient political commitment to carry the proposed strategy through to the implementation phase. A failure to engage all partners in the very beginning of the strategy development process, was, with hindsight, believed to be the main reason for the lack of success. This case also demonstrates that despite strong enthusiasm from concerned health professionals, without the active involvement of all concerned from the outset, the policy-making process is less likely to receive the support and commitment that it requires.

Given the range of causes of, and solutions to, injury problems, stakeholders in any prevention effort will necessarily represent many diverse sectors and disciplines. Some may have little experience in working as part of a multidisciplinary or multisectoral team, and thus have little insight into how other professions and sectors perceive and respond to the problems under consideration. Adopting a multisectoral approach will require engaging in intercultural exchange, overcoming possible prejudice and dealing with competition and possible conflicts of interest. This inevitably requires both time and special communication skills.

Success in violence and injury prevention requires recognizing and complementing the competence and skills of each potential player. In practice, this means that stakeholders must collectively identify the priority problems and focus on how to solve them, before deciding how best their respective core competencies can be used to address the problems that have been identified. Adopting this approach will make it easier to establish what the joint priorities are among the various sectors. Achieving this level of consensus sets the scene for involving people in a neutral, analytical, action-oriented effort, which accepts that no single agency or group can solve the problem of violence and injuries on its own.

Phase 2: Formulating the policy

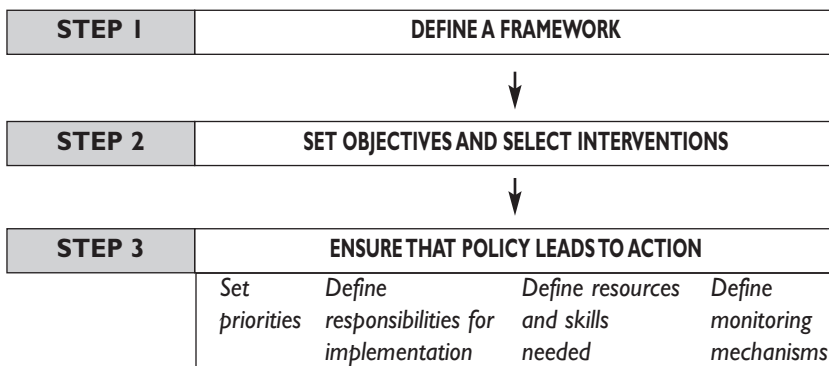
The actual task of drafting a policy document is usually undertaken by an individual or a small group of individuals assigned this role by the lead agency. For national policies, this could be either a group of government employees or a government-contracted consultant or organization. Whoever is selected must have the skills and expertise that are necessary for drafting a policy document; it is especially important that the chosen individual(s) is able to work closely with stakeholders and the lead agency or national committee, and to give due consideration to the views and interests of all stakeholders involved in policy development.

A policy document should be written and structured in such a way that it can be easily understood by representatives of all the different sectors participating in its development and implementation. The use of overly technical words should be therefore avoided. It should include a summary and also a glossary of terms and concepts used.

A three-step procedure for constructing a policy document for injury and violence prevention is shown in **Figure 3**. While this represents the recommended sequence of steps to be followed when drafting a policy document, for practical reasons it may be desirable to alter the order slightly.

Figure 3

A three-step procedure for formulating an injury and violence prevention policy



Step 1: Define a framework

The recommended approach to writing a policy document is to start by establishing, in fairly broad terms, the overall shape and direction that the planned policy will take. This will provide a framework for the remainder of the policy document (**Figure 3**). The opening part of a policy document should thus set out the policy’s goal or goals (often simply worded), a time frame and the policy’s guiding principles (which may be ethical and/or operational). This part of a policy document should also justify the need for the

policy, that is to say, explain — with recourse to data obtained during the course of the epidemiological assessment, in particular, injury mortality and morbidity data (see phase I: step 1) — why action to prevent injuries (or a particular type of injury) is required. Arguments in favour of action can also be based on the analysis of gaps in existing policies and activities conducted as part of the intervention assessment and the assessment of existing policy environment (see phase I: step 1) and should seek to answer such questions as “Where we are?” “Where do we want to be?” “and “How do we get there?”

Setting goals and a time frame

Most successful policy documents include a single statement, sometimes called a “mission statement” or a “vision” which conveys a sense of the policy’s ultimate goal, i.e. what one would ideally wish to achieve by implementing the policy. Such goals are usually idealistic and visionary, specifying neither a time frame nor a quantified target. **Table 3** provides a selection of a “vision” or stated policy goals that have been extracted from existing national policy documents for injury and violence prevention.

Table 3

Selected “visions” or goals of policies for injury and violence prevention

Country	Stated policy goal	Reference
Brazil	Contribute to the quality of life of the population	20
Canada	Canada has the lowest injury rate of any country in the world	8
	Canada will have the safest roads in the world	8
Finland	Finland is the safest country in Europe	23
New Zealand	A safe New Zealand — injury free	24
Sri Lanka	An injury-free Sri Lanka	25
United Kingdom	Creating the conditions for a safer and healthier society	26
Viet Nam	Securing safety for people’s lives and wealth and governmental properties	16

In addition to a stated goal, policy documents should specify a time frame, primarily to provide a reference point for measuring progress made towards policy goals. Policies or strategies tend to have rather long time frames, typically 5–10 years (see **Table 4**). An action plan to implement a policy, or parts of it, will generally be of shorter duration. As illustrated by the Australian example listed in **Table 4**, a long-term policy or strategy can be divided into one or more shorter action plans.

Table 4

A selection of national policies and action plans and their time frames

Country	Policy or action plan	Time frame	Reference
Australia	The National Road Safety Strategy (Australian Transport Council)	2001–2010	27
	The National Road Safety Action Plan (Australian Transport Council)	2001–2002	28
Honduras	Plan nacional para el abordaje de la violencia social en Honduras [National plan to tackle social violence in Honduras]	2001–2005	29
Jamaica	National strategic plan for the promotion of healthy lifestyles in Jamaica	2004–2008	30
Mongolia	National programme on injury prevention	2002–2008	31
Portugal	II Plano Nacional Contra a Violencia Domestica [Second National Plan against Domestic Violence]	2003–2006	32
Viet Nam	National Policy on Injury Prevention	2002–2010	16

Guiding principles

It is important to state the general principles that will guide and shape the planned policy — be they human rights, social justice and equity, the right to health care, respect for the individual's dignity and autonomy, cultural appropriateness, gender considerations, community involvement, the right to a safe environment — as this will place the policy within the national and cultural context. To this end, reference should be made, where applicable, to the national constitution, national health policies, other national policies or strategies, and international treaties that have been ratified and transformed into national law. In each case, it should be explained how injury and violence prevention would contribute to the realization of national ideals and goals.

Examples of how guiding principles have been expressed in national policy documents for injury and violence prevention are shown in **Table 5**.

Table 5

Formulating policies for injury and violence prevention: guiding principles

Country/principle	How the guiding principle is expressed in policy	Reference
<i>The respect for life and the right to live in a safe environment</i>		
Brazil	The right and the respect for life build up an ethical value to health	20
New Zealand	The right to a life without violence	24
<i>The right to health and to health care</i>		
Brazil	Health is a fundamental and essential human right for the social and economic development and social justice	20
Sri Lanka	Every Sri Lankan has the right to the opportunity to be healthy	33
	The right to the avoidance of health risks and fairness in health care services	33
<i>Social justice and equity</i>		
Australia	Equity of access to, and provision of, injury intervention and prevention strategies without prejudice on the basis of cultural background or socioeconomic status	19
New Zealand	Injury prevention activity should aim to reduce inequalities in injury outcomes within and between groups by appropriate allocation of prevention resources	24
Sri Lanka	Sri Lanka is committed to the principles of social justice and equity	33
<i>The respect for dignity, autonomy and cultural diversity</i>		
New Zealand	Injury prevention activity should recognize and respond to the differing needs of Maori; Pacific peoples; and other ethnic groups	24
Sri Lanka	Sri Lanka places the respect for the dignity and autonomy of individuals on the agenda	33

Guiding principles of a rather more operational nature are also often stated in the introductory part of a policy document. These may include an affirmation of a public health approach to injury and violence prevention (i.e. evidence-based decision-making); a commitment to ensuring community participation; a commitment to an intersectoral approach (i.e. one which involves collaboration and coordination between all partners and stakeholders); and an acknowledgement of the respective skills and responsibilities of various partners. Some examples of the ways in which the intent to adopt an

intersectoral and/or a public health approach to injury prevention has been expressed in national policy documents are given in **Table 6**.

Table 6

Formulating policies for injury and violence prevention: operational principles

Country/principle	How the commitment to an operational principle is expressed in policy	Reference
<i>Public health approach</i>		
Australia	The public health approach to injury prevention incorporating a population-based focus	34
Canada	Evidence-based practice is a fundamental guiding principle	8
Mongolia	The preventive measures on protecting the population from injury should be in accordance with the government policies in public health area	31
	Injury prevention activities should be based on the results of research into the factors and causes of injuries and be effective and uncomplicated	31
South Africa	The public health approach is recommended as a logical approach to violence prevention	35
USA	The public health approach to suicide prevention represents a rational and organized way to marshal prevention efforts and ensure that they are effective	36
<i>Working together</i>		
Jamaica	The importance of intersectoral and bilateral work and commitment to integrate programs must respond to the multicausal factors of the problem by providing top-level support and bottom level dedication	37
Mongolia	Preventive measure on protecting the population from injury should be based on the coordinated activities of individuals, communities, state and nongovernmental organizations and business entities	31
	Injury prevention activities should aim at increasing the obligations and responsibilities of state and nongovernmental organizations, business entities, private individuals and communities	31
Sri Lanka	Community participation in all aspects is a critical element underlying this policy	33
USA	Emphasizes coordination of resources and culturally appropriate services at all levels of government - federal, state, tribal and community - and with private sector	38

Step 2: Set objectives and select interventions

Deciding on policy objectives

The main body of the policy document is reserved for setting out a series of more detailed objectives for achieving the stated policy goal(s). Objectives thus describe outcomes that through implementation of the policy one would hope to achieve. In many areas of public health, including injury, policy objectives tend to relate to the incidence or the frequency of an event (e.g. mortality, disability, morbidity, socioeconomic burden, disparities) or the prevalence of risk factors (e.g. level of exposure). It is generally preferable to set measurable, time-limited objectives; these can be expressed in terms of a percentage reduction (or improvement) to be achieved by a certain date. Baseline data are therefore needed to quantify an objective. In many low- and middle-income countries, however, the relevant data may not be available, in which case it will be necessary to formulate a descriptive objective. Selected examples of national objectives for injury prevention, some of which set quantified targets and some of which do not, are provided in **Table 7**.

Table 7

National policy objectives for injury prevention: selected examples

Country	Main policy objective	Reference
<i>Quantified targets</i>		
Netherlands	By 2010, road deaths should be reduced by at least 50% and injuries by 40%, compared with 1986 baseline figures	4
United Kingdom	Reduce the number of children killed or seriously injured by 50% and people killed or seriously injured in road accidents by 40%	26
<i>Not quantified</i>		
Canada	To reduce the incidence and severity of 1) fall-related injuries among children, elderly and workers, 2) motor vehicle collisions and transportation related injuries 3) self-inflicted injuries and suicide	8
Finland	To reduce the rate of fatal and serious injury from accidents	23
Mongolia	Decrease the mortality, number of disabled and handicapped people due to injury	31

To ensure that proposals for action are both comprehensive and coherent, these guidelines recommend that a “tiered” or hierarchical approach to drawing up policy objectives be adopted. Thus, for each main policy objective (say a reduction in the mortality rate due to road traffic injuries) several separate objectives should be defined,

corresponding, where relevant, to each of the following components of injury prevention and control:

1. Reductions in the exposure to risk and prevention of incidents from occurring, through the adoption of safer behaviours and safer environments.
2. In the event of an injury, reductions in the severity of injury and its impact, by designing and implementing protective mechanisms.
3. Reductions in the consequences of injury through post-event care (e.g. emergency care, essential trauma care, physical and psychological rehabilitation).

Examples of objectives that correspond to each of these three areas of injury prevention, (primary prevention, reduction of direct consequences and provision of care), taking the specific case of road traffic injuries, are shown in **Table 8**.

Table 8

Objectives for policies aimed at reducing road traffic injuries

Country	Policy objective	Reference
<i>Reductions in exposure to risk/prevention of incidents</i>		
Australia	Improve road-user behaviour	27
	Encourage alternatives to motor vehicle use	27
South Africa	Ensure an acceptable level of quality in road traffic, with the emphasis on road safety, on the South African urban and rural network	39
<i>Reductions in the severity of an injury</i>		
Australia	Improve vehicle compatibility and occupant protection	27
<i>Reductions in the consequences of an event through post-event care</i>		
South Africa	Optimize emergency response, acute care and rehabilitation services to those who are affected by injury	39

Each objective may then have a set of subobjectives. These can be viewed as intermediate steps towards the attainment of a defined objective. Possible subobjectives include, again taking the prevention of road traffic injuries as the example:

- to set and enforce speed limits (e.g. to reduce average speed on highways to 80 km per hour by 2007);
- to enforce alcohol impairment laws;
- to regulate drivers' hours of work in commercial and public transport.

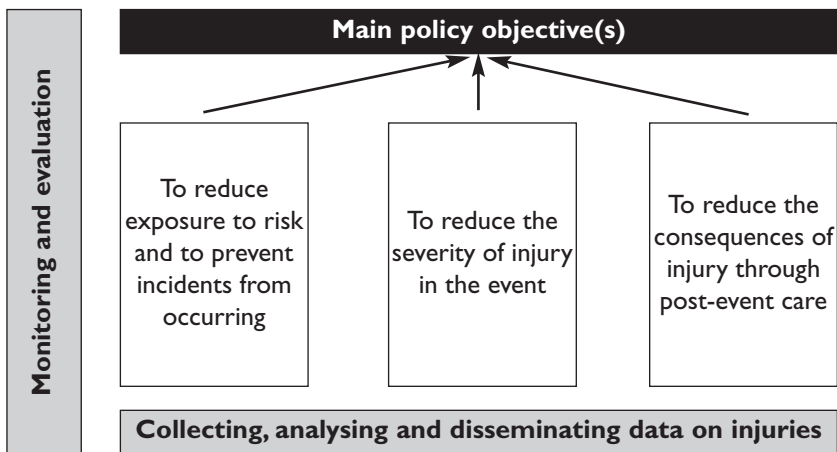
Subobjectives tend to focus on mechanisms that are known to directly and positively influence the issue of interest. They are usually formulated as an improvement (for example, to increase, to enhance, to improve, to optimize, to strengthen, to develop) and often are not quantified due to a lack of appropriate baseline data.

To support this systematic approach to setting and defining objectives, it is essential to have good data on injury prevalence, coupled with mechanisms for the monitoring and evaluation of interventions. The interrelationships between the tiers of policy objectives, and the activities that support them are illustrated in **Figure 4**. This figure highlights several important points:

- The objectives that correspond to each of the three different phases in the history of an injury (i.e. before the event, during the incident and after the event) are all striving to achieve the same overall objective, and ultimately the policy goal(s).
- A good surveillance system is the foundation on which efforts to prevent injuries are built.
- Monitoring and evaluation are ongoing activities throughout all stages of policy development and in all areas of injury and violence prevention.

Figure 4

A systematic approach to setting policy objectives for injury and violence prevention

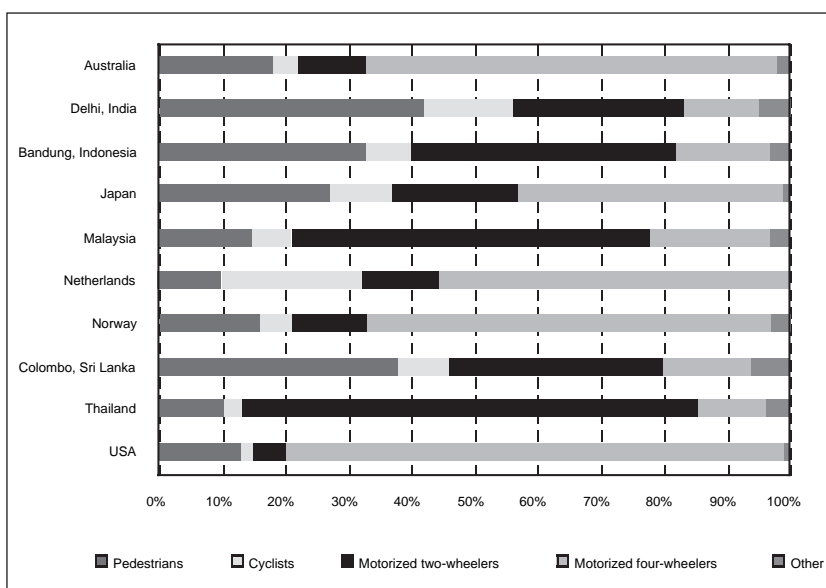


Some policy documents include objectives that are directed at improving the quality of the database that supports policy-making. The need to collect, analyse and disseminate data on injuries by increasing research and programme evaluation on injury causes, injury programmes and practices is recognized in the Canadian policy instrument (8). Similarly, the Australian National Road Safety Strategy (27), has as one of its objectives, “to increase the availability of, and access to, comprehensive provincial injury surveillance data”.

The number of objectives and subobjectives will depend to a large extent on the scope of the policy (e.g. the type of injury, the target population group) and national

circumstances. For instance, a breakdown of road traffic deaths, by type or road user (see **Figure 5**), reveals significant differences in the vulnerability of different categories of road users between countries. In the United States of America, for example, car drivers or passengers account for almost 80% of road traffic injuries. In Thailand, the most vulnerable group are motorcyclists, whereas in India pedestrians bear the great burden of road traffic-related injury deaths. The objectives and subobjectives of policies to reduce road traffic injuries will thus be very different in each of these situations. This also serves to illustrate just how important data on injury patterns are for formulating appropriate policy objectives.

Figure 5
Road users killed in various modes of transport as a proportion of all road traffic deaths



Source: reproduced from reference 4.

Determine interventions

As well as setting objectives, the policy document should also propose a series of measures or interventions for attaining them. The full range of potential interventions should be considered, in order to determine which are going to be most useful in the national context and given the scope of the policy. The policy should support proven and/or promising interventions, and advocate withdrawing support for interventions shown to be ineffective. When considering interventions for injury and violence prevention, it is important to recognize that there is no such thing as a standard set of technically sound and effective interventions that can be universally applied. For certain types of injury, there may well

be some well-tested interventions that are likely to be effective in most settings (e.g. the wearing of seat-belts and motorcycle helmets), but for others there is little evidence regarding their effectiveness to draw on (e.g. domestic violence). Moreover, even well-tested interventions may not be equally effective in all settings. This is a consequence of the relative newness of the field of injury prevention, but perhaps more significantly, of the highly contextual nature of the causes of and risk factors for injuries and violence, and the population groups most at risk. At present, evaluations of the effectiveness of interventions are largely limited to those that have only been carried out in high-income countries, but these may not necessarily apply to other settings, or the methods of implementation may need to be modified to achieve comparable levels of effectiveness. The lack of solid or directly transferable evidence does not, however, imply that nothing can be done. In the absence of such evidence, the best available information on effectiveness should be reviewed in the context of the local situation and circumstances, and on this basis, a decision taken as to whether an intervention looks promising and should therefore be pursued, or if it should be modified in some way to increase its chances of success (see **Box 18**). Generally speaking interventions proven to be ineffective in other settings should not be considered. For instance, recent studies have revealed certain interventions previously thought to be effective for reducing youth violence, or the risk factors for youth violence, to be ineffective (see Annex 3).

BOX 18

“Effective” interventions may not work in isolation

During the last decade, several initiatives to protect women against domestic violence have been instigated in Nicaragua. These have included:

- the creation of a network of police stations for women (Comisaria de la Mujer), where abused or beaten women can find psychological, social or judicial advice and help for their problems;
- a new ministry for family affairs (Mi Familia), which among other things, ensures that shelter is available to women and children who have been victims of domestic violence;
- integration of gender issues and sexual abuse into the national reproductive health programme.

At the same time civil activist groups have campaigned tirelessly to promote the rights of the women and to empower them to make a stand against all forms of domestic abuse.

Despite these efforts, the reported number of violent acts against women (domestic violence and sexual violence) has increased dramatically: the number of reports of sexual abuse received by the Comisaria de la Mujer rose from 4174 (January–June 2003) to 8376 (January–June 2004). According to researchers from the Social Sciences Department of the Universidad Centro Americana and from the Institute for Gender Studies, there are two main reasons for the increase in reported violence:

- better reporting of cases, as women are encouraged to do so by activist organizations;
- increased consciousness among women that the cultural tradition is no longer acceptable according to international laws (this has generated a more active resistance to male hegemony, which in turn has led to an increase in the number of domestic conflicts and violent responses from men).

These findings suggest that the response to violence needs to be modified; instead of focusing on women, interventions must also target men. If increasing the capabilities of resistance among women is not linked to interventions for men, acts of violence will not diminish.

The effectiveness of preventive measures is typically expressed in terms of the number of lives saved, injury cases avoided or disabilities prevented. Ideally, such figures should be based on the results of studies conducted in the same country for which the policy is being developed. In practice, however, policy-makers may have to rely on data reported in the scientific literature from other countries, in which case, it is preferable to use data derived from a similar setting (e.g. survey results for a neighbouring country). While there are obvious limitations to estimates derived in this way, it is generally preferable to lead the policy debate with concrete science-based evidence from other countries, rather than rely on vague arguments or anecdotal evidence.

Aside from the question of effectiveness, there are a number of other important factors to consider, namely the feasibility, acceptability, cost-effectiveness and measurability of interventions. The issue of cost-effectiveness is frequently raised in evaluations of potential solutions, but this is often difficult to assess and is not always the most relevant parameter. A cost-effective solution does not necessarily mean that it will be low cost. With scarce resources in low- and middle-income countries, a low-cost solution may be more feasible than high-cost solution even though the latter might be more cost-effective, especially in the longer term.

Both the *World report on violence and health (2)* and the *World report on road traffic injury prevention (4)* propose a range of interventions for tackling these types of injury, including some that have been well tested, albeit predominantly in high-income countries. These are listed in Annex 3. By way of an example, possible interventions for achieving a level of seat-belt use of 90% among drivers and passengers include:

- increasing acceptance by the general population that the wearing of seat-belts is an effective measure for reducing the severity of vehicle crash injuries;
- promulgation of mandatory laws and regulations concerning the wearing of seat-belts;
- effective punishment/penalty for non-compliance with seat-belt laws, coupled with endorsement measures and appropriate allocation of resources;
- systematic and permanent implementation of enforcement measures.

It is interesting to note that certain of these measures have to be fulfilled before others. Some are obvious: wearing a seat-belt is only possible if the vehicle is fitted with seat-belts, and imposing penalties is only possible if the relevant legislation is in place. Some, however, are more complex: for instance, it will be easier to enforce mandatory seat-belt use if a significant proportion of the population already considers this to be of collective and individual interest.

To summarize, the recommended sequence of steps to be followed in order to complete step 2 of the policy formulation process, is as follows:

- I. Define objectives corresponding to each of the three components of injury control (i.e. primary prevention, reduction of direct consequences, provision of care), based on national data on injury patterns and international experience.

2. Set subobjectives for reaching the objectives defined for each of the above injury control components.
3. By drawing on national and/or international experience, identify the most relevant interventions for each subobjective, bearing in mind their likely effectiveness under local circumstances, and also their feasibility, acceptability, measurability and, if relevant, cost-effectiveness.
4. Describe, if necessary, the sequence in which interventions need to be implemented in order to achieve maximum effectiveness.

Step 3: Ensure that policy leads to action

To make sure that a policy is workable in its implementation phase, various practical matters will need to be discussed and agreed during its development. These include the setting of national and local priorities, agreeing respective roles and responsibilities, establishing coordinating mechanisms, and identifying human and financial resource needs and funding sources. Any potential constraints and limitations, as well as factors that might work in favour of the policy, should also be considered at this stage. Only then can all stakeholders and political authorities be expected to reach consensus on the policy and take the necessary steps towards its implementation.

Setting priorities

By this stage of the policy development process, the scope of the policy will have already been decided, that is to say, it will have been decided whether the policy will address all injuries or a specific type of injury, (e.g. domestic violence or road traffic injuries), and whether the policy will stand alone or form part of an existing policy initiative (see phase 1: step 1). In most cases, the magnitude of the burden of certain types of injury is the main deciding factor. Occasionally others factors, such as preventability, knowledge of effective interventions, identity of the high-risk population groups, existing (or gaps in) policies and programmes, availability of resources for prevention and control (e.g. financial, staff, skills) and the political environment, play a decisive role in shaping the scope of the policy. In the example described in **Box 19**, prevention effort is directed at road traffic injury rather than violence, despite the fact that the latter is responsible for more deaths, because the political environment is more conducive to developing a policy to reduce deaths due to road traffic crashes.

Nevertheless, at this stage of the process, it can be helpful to set priorities *within* the chosen scope of the policy, especially if the reaction from stakeholders once policy objectives have been defined and appropriate interventions proposed is, "This is too much" or "We can't do it all at once". In this case, it is necessary to decide what should come first, and what may be left for a later stage, if and when more resources become available. Given that resources are often the limiting factor, it may be prudent to give priority to those problems that impact on the largest proportion of the population (as

determined through the situation analysis, see phase I: step 1) and/or for which the greatest political support and commitment can be gained (see **Box 19**).

BOX 19

Setting priorities in Brazil

A Brazilian policy on injury and violence prevention, the *Política nacional de redução da morbimortalidade por acidentes e violências* [National policy on morbidity and mortality reduction due to accidents and violence (20) was officially approved in 2001. Although available data showed that homicides were the leading cause of violent deaths, followed by road traffic crashes, the Ministry of Health elected to make the reduction of deaths due to road traffic crashes its top priority. If priorities had been set based solely on epidemiological evidence, the reduction of deaths due to homicide would have had a higher priority. This decision was influenced by the fact that the 1998 traffic code cites, as its most important objective, security and life preservation. Thus, the existing traffic code provided an important political opportunity to rapidly engage in activities to prevent injuries and deaths due to road traffic crashes.

Policy priorities are sometimes determined by the feasibility of potential interventions (i.e. what can realistically be achieved given the available human and/or financial resources) and the strengths (or weaknesses) of existing programmes and services. The political timetable can also be a decisive factor in terms of defining priorities. Politicians in elected office often opt for short-term successes. To demonstrate that progress can be made in the short-term while working towards longer-term policy objectives and goals, it may be useful to group interventions into those with rapid preventive effects that occur within 12 months (e.g. enforcement of laws regulating alcohol sales, distribution of safe and safety products, installation of traffic calming measures); those where there is moderate delay of between 12 and 36 months between intervention and effect (e.g. implementation and evaluation of motorcycle helmet wearing laws, job creation programmes); and those where there is a longer delay, 36 months or more (e.g. social development programmes, retrofitting of seat-belts into the existing motor vehicle fleets, implementation of water safety, swimming and lifeguard training programmes, home visitation and parent training).

The setting of priorities should always be a collaborative process, involving all interested parties, including potential beneficiaries. As stakeholders may well have different ideas about what the priorities should be, creating consensus may not be easy. A transparent consultative process, supported by scientific evidence should, however, help to make the final decision more acceptable to all concerned. As a final point, it is worth bearing in mind that it may only be possible to define priorities at the national level during the policy development process, but that during the implementation phase it will also be necessary to set priorities at the regional or local level.

Defining responsibilities and coordination mechanisms

It will greatly assist the implementation of a policy if institutional responsibilities and coordination mechanisms between ministries and other national entities can be defined in the policy document. This generally involves attributing overall leadership for policy implementation and assigning responsibilities for various aspects of policy implementation.

Assuming leadership of policy implementation usually also implies taking responsibility for coordinating the contributions and inputs of all parties involved; this is usually a particularly important function of the lead agency. Tasks assigned to the lead agency for policy implementation in Nova Scotia, Canada are summarized in **Box 20**. This example provides a good model and illustrates particularly well the broad range of responsibilities that rest with the lead agency.

BOX 20

Functions of the lead agency for policy implementation in Nova Scotia, Canada

In short, the role of the lead agency is to secure the means and necessary support for ensuring the ongoing development, implementation, monitoring and evaluation of efforts to prevent injury. More specifically, this entails performing the following functions (10):

- Continuous review and analysis of the extent and nature of the injury problem through the development of a comprehensive surveillance system.
- Identification of the main targets for injury prevention activities using surveillance data.
- Identification of the most appropriate public policy and legislative formats for reducing injuries.
- Quantifying the resources required for policy implementation (both existing and any additional resources that may be needed in the future).
- Monitoring and evaluating the effectiveness of the policy.
- Keeping abreast of developments in the field of injury prevention and dissemination of this type of information to stakeholders.
- Building local community-based capacity to prevent injuries and ensure long-term sustainability of injury prevention.
- Coordination of provincial injury prevention communications and social marketing plans.
- Working with the government to draft and implement a national injury prevention framework and policy.
- Identification of potential opportunities for collaboration with other provincial governments.

The entity designated to lead the implementation of the policy tends to vary from country to country. For example, in Canada, the Office of Health Promotion became identified as the lead agency responsible for the coordination of injury prevention activities across government (8). In Viet Nam, the National Steering Committee of Injury Prevention Programme, chaired by the Minister for Health, is responsible for the implementation of the national plan for injury prevention (16). In some countries, lead agencies are designated for specific tasks relating to injury and violence prevention. In Finland, the Ministry of Interior is responsible for the reporting and updating of the Internal Security Programme, which deals with issues such as violent crime, public disturbances and accidents (23). In Sri Lanka, the police department together with the transport and highways department is responsible for implementing road traffic injury prevention measures (25). In Viet Nam, the Ministry of Culture and Information is responsible for developing and organizing information, education and communication activities on injury prevention in the mass media (16).

In many countries, public systems, including the health service, are being increasingly decentralized. The growing trend towards decentralization of health services can have

significant implications for national policy implementation in that it will require the collaboration of provincial and district health authorities. For logistical and administrative reasons, however, it is often difficult to fully involve the district/provincial level providers into the policy development process. Given that district/provincial health authorities usually have responsibility for implementing new health policies and initiatives, it will be advantageous in the longer term to sensitize individual health authorities to the policy early on. This could be achieved by holding a series of consultative meetings and workshops. Subsequently there may be a need for training and other support mechanisms to assist individual health authorities adapt policy initiatives to their own circumstances and problems. In Viet Nam, for example, a two-year training and development programme was established in order to support provincial public health doctors in the implementation of injury prevention plans.

Defining resource needs

It will not be possible to implement a policy without adequate financial and human resources. As part of policy development it is thus paramount that: a) human resource needs, including training, are estimated; b) the costs of implementing the policy are broken down by component and by intervention chosen; and c) national and international funding sources are identified. Ministries or agencies with overall responsibility for policy implementation should adjust their budgets accordingly and/or secure additional financial support from donors. Failure to fully address resource needs for implementation during the policy development phase can jeopardize the future success of the policy (see **Box 21**).

BOX 21

The Polish Act on National Emergency Medical Services: a lesson in resourcing

Formulated by the Ministry of Health, the Act on National Emergency Medical Services (EMS) was adopted by the Polish Parliament in July 2001 (40). This act made the provision of emergency medical services to any person facing a sudden life or health threat the responsibility of the state, and to this end the National Emergency Medical Services System was established.

In its original form, the act is a very comprehensive piece of legislation, consisting of 45 articles. However, it was not adopted by parliament in its entirety, largely because of financial reasons. Although the act allowed for the cost of implementing the EMS, it failed to evaluate the financial resources that would be required for its routine functioning. Thus those parts of the act that relate to the structural organization of the EMS (including standard procedures, coordination of all subdivisions of the EMS, training programmes in emergency medicine, pre-hospital data collection and the status of paramedics) entered into force in January 2002, but the parts referring to the financial considerations were not endorsed and thus will not be acted on.

Defining mechanisms for monitoring and evaluation

One final aspect to consider when drafting a policy document is the question of monitoring and evaluation. In doing so, it will be necessary to distinguish between evaluating the policy development process and evaluating progress made in implementing the policy. Both are important. As the preceding discussions have shown, policy

development and policy implementation are inextricably linked and the influence of the former on the latter should not be underestimated.

Evaluating the policy development process itself usually means determining what went right and what went wrong, and for what reasons. The sorts of questions that may be instructive to ask at this point are:

- Who initiated the policy process and why?
- Which stakeholders were involved in the process and when? Which stakeholders were not involved and why?
- Were the expectations of the stakeholders fulfilled? If not, why not and for what reasons?
- What difficulties arose during the development process and how were they addressed?
- How were responsibilities assigned and coordination mechanisms decided?
- What were the results of the different meetings organized during the development process?
- Was the endorsement process successful?
- How was the launch of the policy document communicated to the media and the general population?

The importance of evaluating the policy development process should be acknowledged and communicated to all partners early on. Adequate resources, human as well as financial, should also be allocated at the outset of the process, to ensure that the evaluation takes place at an appropriate time, and the results are disseminated.

While it is not necessary that a policy document includes precise details of how policy implementation will be monitored and evaluated (this will form part of more specific action plans that will be drafted once the policy has been approved), it should nevertheless emphasize the importance of documenting progress in preventing violence and injuries and assign responsibilities for evaluating the implementation and impact of the policy. It should also stipulate that adequate resources be set aside for monitoring and evaluation activities. It is generally advisable to define a review process, setting out who will be responsible for monitoring progress, at what intervals progress should be reported and to whom, and how implementation can be enforced if needed, as early as possible. A feedback mechanism should be put in place to allow the regular revision of a policy, should it be necessary, to improve its accuracy and relevance. The Australian experience in injury prevention, reported in **Box 22**, demonstrates just how vital this feedback loop can be.

BOX 22

Translating policy into action: Australia's experience with a National Injury Prevention Plan 2001–2003

Australia's first attempt at utilizing a national plan to drive investment in injury prevention was not thought to be particularly successful. It relied on the uptake by individual states (or at the national level) of a range of proposed strategies for injury prevention; the proposed strategies included those for which there was good evidence of effectiveness and also those that might be effective but for which further evidence of effectiveness was required (i.e. "generating evidence"). The intention was that representatives from various state health departments and national groups would report, at regular national meetings, on progress made against their nominated strategies.

Since Australian states are a federation, no one organization has the power to insist that health departments in various states take responsibility for the development of prevention strategies, which might then be adopted nationwide. The reporting mechanism mentioned above was the only forum in which any accountability was demonstrated.

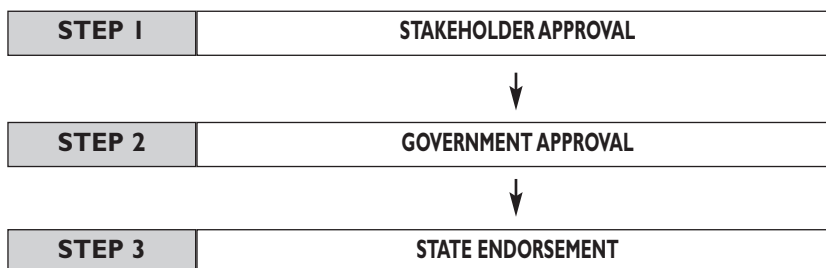
The implementation plan was subsequently formally reviewed in order to find a better approach. Key issues identified were poor engagement with injury prevention groups around the country, the lack of specified resources for various aspects of the plan, a lack of coordination with other key agencies and stakeholders, and a lack of performance measures. These gaps are currently being addressed and a second national plan is in development.

Phase 3: Seeking approval and endorsement

Approval and endorsement of a policy, the third and final phase of the policy development process, needs to come from several quarters, and ideally should be sought sequentially, firstly from stakeholders, then government and lastly, from parliament (i.e. state endorsement) (**Figure 6**). While it is important to always start with the stakeholder groups, in some countries, it will be necessary to obtain state endorsement before government approval.

Figure 6

Three-step approach to securing policy approval and endorsement



Step 1: Stakeholder approval

One way of seeking approval from stakeholders, is, once the policy document is at an advanced draft stage, to convene a consultative meeting which brings together all stakeholder groups. The aims of such a meeting would be, firstly, to reach consensus regarding the structure and content of the policy document by allowing all stakeholders the opportunity to comment on the draft, and secondly, to discuss opportunities for, and constraints on implementing the policy. Meeting organizers would be well advised to anticipate tensions between representatives of different sectors and to pay special attention to preparing means of overcoming them.

After the consultation, and following further rounds of negotiations and revisions to the text, the policy document should be issued in its final form and copies sent to all stakeholders. Having their approval and commitment is very important, not least because stakeholders are often in a strong position to advocate for policy implementation, even if the political climate becomes less favourable. One-on-one lobbying of key influential persons can be a particular strength of certain stakeholders, and is sometimes an effective means of enlisting support for a policy.

Step 2: Government approval

Before a policy is officially recognized by the state or legislative body, it needs to undergo a formal approval process. In most countries, policies need to be approved by a government ministry first, and then by the cabinet, the council of ministers (see **Box 23**) or the leader of the country (see **Box 24**). When seeking government approval of a policy, it can be an advantage if a person or an organization from within government takes on the leadership role for this task. In the case of the road traffic injury prevention policy, adopted in Thailand (**Box 24**), the Deputy Prime Minister provided the strong leadership role. This allowed rapid government endorsement, and in turn led to substantial resources being allocated to road safety and effective action at the provincial level. As a final point, it is worth bearing in mind that it is not always necessary to wait until cabinet approval before taking steps to implement a policy that has been approved at the ministerial level.

BOX 23

Developing a child injury prevention plan in Cyprus

In March 2002, and in response to growing concerns voiced by the Cyprus Paediatrics Society about unintentional injuries in children, the Ministry of Health of Cyprus decided that a coordinated approach to childhood injury prevention was needed. It therefore established an Advisory Committee for the Prevention of Childhood Injuries and Poisonings. The multisectoral Advisory Committee comprised 18 people from 16 different organizations, services and government departments and was accorded an advisory role to the Minister of Health in matters relating to unintentional injuries in childhood. Following an assessment of the scale, type and causes of injuries in childhood, coupled with an analysis of the current situation with regard to prevention (in terms of existing legislation and structures, health promoting activities and data collection activities), the Committee undertook to develop a strategic plan for the prevention of childhood injuries. As part of the assessment process, models of best practice in injury prevention at the European and global level were examined.

In November 2004, a two-day workshop was held in Nicosia. The workshop was coordinated by the Ministry of Health, with expert input from WHO, the Athens University Medical School, and the Hadassah and Hebrew University, Jerusalem and strong participation from local stakeholder groups with interests in injury prevention. During the workshop, priorities for childhood injury prevention in Cyprus were identified, as were gaps in data collection and injury prevention activities. A framework for the development of a strategic plan for injury prevention was drafted by the participants, bearing in mind available evidence regarding the effectiveness, affordability and appropriateness of suggested interventions.

The five-year year strategic plan was completed and submitted to the Ministry of Health in May 2005. The plan sets out activities for injury prevention in three different age groups (0–4 years, 5–14 years and 15–18 years), assigns responsibilities to various stakeholders and proposes a time frame for implementation. It also outlines monitoring needs and introduces a set of indicators to be used for evaluating progress. In September 2005, the Ministerial Council of Cyprus approved a proposal to formally adopt the plan.

BOX 24

Strong leadership leads to a rapid cabinet resolution on road safety in Thailand

In the past, Thai public holidays, particularly the new year and Song Kran festivals, were noted for their alarmingly high road casualties, a fact that was repeatedly reported in the press. Over a period of several years, increased public concern about road traffic injuries resulted in pressure being brought to bear on politicians and bureaucrats to do something about it (see also Box 13).

In 2003, under the direction of a new Thai government, a concerted effort was made by responsible public agencies to curb the death toll, and an ambitious target of a 20% reduction in road deaths during the 7-day new year festival was set. A “war room” was created, chaired by the Minister of Interior and co-chaired by deputy ministers from other ministries. This was the strongest commitment ever made to road safety, and led to extensive law enforcement activities throughout the country (see also Box 13).

Immediately after the new year festival, the Deputy Prime Minister announced a long-term policy commitment to road traffic injury prevention. Under his leadership, a series of meetings were held to formulate strategies and action plans, culminating seven months later, in a cabinet resolution endorsing the proposed strategies and action plans. The plans, which cover law enforcement, public education, traffic engineering, emergency services and information systems, provided both national- and provincial-level public authorities with a strong framework for action. Although initially financed on an ad hoc basis, by the end of 2003 a regular budget was dedicated to road safety.

The development of road traffic injury prevention policy in Thailand is particularly interesting in that although the provinces themselves were responsible for much of the policy-making — the majority of plans for action were laid down by multisectoral public agencies at the provincial level — the individual action plans were very much in line with national goals and objectives. This was achieved largely because of the influence of the Provincial Accident Prevention Committee, an umbrella body that was revitalized after decades of inactivity.

Step 3: State endorsement

Given that policy implementation usually requires the collaboration of several ministries, and that its impact is dependent on a long-term commitment, it is highly desirable that the policy be approved at the highest level of government (i.e. by the leader or the cabinet), be ratified by parliament and given a legal basis. Having a policy document approved in an official document of the state (i.e. the legislature), and preferably in law — rather than solely by government (i.e. the administrative branch) — is considered

to be the better option, for the simple reason that law tends to be more resistant to changes in the political climate and in governments and their leaders.

Inevitably, it takes some time for any policy document to make it through the political processes required for its adoption and endorsement. Indeed, many policies languish as drafts for months, even years, because of the length and complexity of the political and/or legal processes that need to be completed before a policy can become official. Nevertheless, a policy or strategy that does not pass some form of official state or legislative body approval (as opposed to approval from the government's administrative branch) runs the risk of being neglected in the long term. Advocacy, lobbying and media communication can be pivotal to the approval process in that they periodically remind both the general public and policy-makers of the issues at stake and help to keep the policy firmly at the forefront of the political agenda.

Concluding remarks

When developing injury prevention policies, it may not always be possible to follow exactly the stepwise methodology recommended in these guidelines. In real life, the policy development process is often far more haphazard than the model scenario portrayed here. For instance, it may be necessary to jump ahead and then come back to a step that in an ideal world might have been better tackled earlier on. Although this may prolong the development of the policy or delay its implementation, it — hopefully — will not jeopardize its existence. Nor does it matter what the final document to emerge from the policy development process is called, just as long as its contents clearly show the way ahead.

At the risk of appearing repetitive, it is nevertheless extremely important to remember that the policy development process is as important or maybe even more important than the final published document. Only a transparent, fully inclusive process can ensure ownership and commitment of all partners. Too many policy documents have been left to gather dust on a shelf because the process at some level failed in these respects.

The diversity in the nature of injuries and in their risk factors pose major challenges to those seeking to propose ways of reducing their health impact. The fact that some issues may be very sensitive socially, that resources are limited, and more often than not we simply do not know what is the best approach for solving a specific problem can make a difficult task seem even harder. However, much experience has accumulated over the past years; we know now what works in certain settings and what does not. The challenge is to adapt this knowledge to other settings, and to do so within a coherent, understandable framework. In this respect a well-designed policy is invaluable: it raises awareness, creates understanding and, moreover, provides a common goal — with some suggestions as to how to achieve it.

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Annex I.

Selected policy documents relating to violence and injury prevention

Region or country	Title of policy document	Internet link (Accessed 13 January 2006)
<i>Violence and unintentional injuries</i>		
Australia	Aboriginal safety promotion strategy	http://www.health.nsw.gov.au/pubs/a/pdf/ab_safety.pdf
Brazil	Política nacional de redução da morbimortalidade por acidentes e violências [National policy to reduce morbidity and mortality due to accidents and violence]	http://conselho.saude.gov.br/comissao/acidentes_violencias2.htm
Canada	Report on proposed national priorities for injury prevention and control	http://www.injurypreventionstrategy.ca/background.html
	Ending Canada's invisible epidemic. A strategy for injury prevention	http://www.injurypreventionstrategy.ca/downloads/NatPrioritiesDec2001.doc
	Developing an integrated Canadian injury prevention strategy ¹	http://www.injurypreventionstrategy.ca/downloads/IP_Strat_bckgrnd.pdf
	Workbook for developing an integrated Canadian injury prevention strategy ²	http://www.injurypreventionstrategy.ca/downloads/IP_Strat_wrkblk.pdf
	Strengthening Manitoba: developing a provincial injury prevention strategy	http://www.hsc.mb.ca/impact/strengthening_ip_strategy.htm
	Nova Scotia injury prevention strategy: report and recommendations	http://www.gov.ns.ca/ohp/InjuryPrevention/ns_strategy.html
	Alberta injury control strategy	http://www.injurypreventionstrategy.ca/downloads/Alberta_IP_Control_Strategy.pdf
Viet Nam	National policy on injury prevention for 2002–2010	http://www.norsafety.no/SCWN/2002/SC%20WNEWS3%20January%202002.pdf
	Implementation plan for the National Policy on Accident and Injury Prevention: 2002–2010 National programme of action, sectoral and local plans of action on accident and injury prevention 2003–2005	
<i>Unintentional injuries</i>		
Australia	National injury prevention plan priorities for 2004 and beyond. Discussion paper	http://www.nisu.flinders.edu.au/pubs/reports/2003/injcat55.pdf
	The draft National Injury Prevention Plan 2004 onwards	http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-pubhlth-strateg-injury-consult_plan.htm/\$FILE/draft_nipp_consult_19aug04.pdf

	The Health Outcomes Plan – Injury Prevention and Control 2000– 2004 (Queensland)	http://www.health.qld.gov.au/hop/injury_full.pdf
Mongolia	National programme on injury prevention	
New Zealand	New Zealand Injury Prevention Strategy	http://www.nzips.govt.nz/documents/strategycolour.pdf
Sri Lanka	National policy framework on injury prevention in Sri Lanka	
	Report on formulation of national policy framework on prevention of injuries	
United Kingdom	Preventing accidental injury: priorities for action	http://www.dh.gov.uk/assetRoot/04/06/49/50/04064950.pdf
	Avonsafe Injury Prevention Alliance Strategy 2001–2006 (Bristol)	http://www.avon.nhs.uk/phnet/Avonsafe/strategy.pdf
	Proposal for injury prevention in Wales	http://www.capic.org.uk
USA	Safe States. (Core components of State injury prevention programs)	http://www.stipda.org/documents/ss03.pdf
South-East Asia	Strategic Plan for Injury Prevention and Control in South-East Asia	http://w3.whosea.org/LinkFiles/whd04_Documents_Accident-8.pdf
Road traffic injuries		
Australia	The National Road Safety Strategy 2001–2010	http://www.atcouncil.gov.au/documents/pubs/strategy.pdf
	The National Road Safety Action Plan 2001–2002	http://www.atcouncil.gov.au/documents/pubs/actionplan_01_02.pdf
	The National Road Safety Action Plan 2003–2004	http://www.atcouncil.gov.au/documents/pubs/actionplan.pdf
	The National Road Safety Action Plan 2005–2006	http://www.atcouncil.gov.au/documents/pubs/ACTION_PLAN_05_06.pdf
Canada	Road safety vision 2010	http://www.ccmta.ca/english/pdf/rsv_report_02_e.pdf
	Safer drivers in safer vehicles on safer roads: an initiative to action	http://www.caa.ca/PDF/Safer%20roads%20-%20invite%20to%20action%20-%20final.pdf
Czech Republic	New road safety strategy in the Czech Republic	http://www.cdv.cz/english/text/branch/road/newroad.htm
Fiji	Fiji's Road Safety Action Plan	http://www.unescap.org/ttdw/Publications/TIS_pubs/Pub_1996/Pub_1996_annexA.pdf
France	Les actions locales de sécurité routière [Local actions on road safety]	http://www.securiteroutiere.equipement.gouv.fr/infos-ref/politique/actions/les-actions-locales-de-securite-routiere.html
Ireland	Road Safety Strategy 2004–2006	http://www.transport.ie/upload/general/2655.pdf
Kenya	Road Safety Improvement Project	
Lesotho	Road Safety Improvement Project	http://www.vejdirektoratet.dk/dokument.asp?page=document&objno=11005
Netherlands	Sustainable Safety: a new approach for road safety in the Netherlands	http://www.rws-avv.nl/pls/portal30/docs/1771.PDF
New Zealand	Waikato Regional Land Transport Strategy: operative strategy 2002–2012	http://www.ew.govt.nz/policyandplans/rlts/strategy/index.asp
	Strategic Plan to 2006	http://www.ltsa.govt.nz/ltsa/about/strategic-plan-to-2006/strategic-plan-to-2006.pdf
	Land Transport New Zealand: research strategy 2006–2007	http://www.ltsa.govt.nz/research/documents/research-strategy-2006-2007.pdf
	Road safety to 2010	http://www.ltsa.govt.nz/strategy-2010/docs/2010-strategy.pdf

Norway	Road safety in Norway: strategy 2002–2011	http://odin.dep.no/filarkiv/160260/Road_Safety.pdf
Poland	National programme of road safety improvement in Poland: GAMBIT 2000	
South Africa	The road to safety 2001–2005	http://www.transport.gov.za/projects/rts/index.html
Spain	Plan nacional de seguridad vial para 2004 [National plan on Road Safety for 2004]	http://www.dgt.es/dgt_informa/notas_prensa/041203plan.pdf
Sweden	Vision Zero: from concept to action	http://www.vv.se/filer/publikationer/nollvisionen_eng.pdf
Tanzania	Road safety programme	
United Kingdom	Tomorrow's roads safer for everyone	http://www.dft.gov.uk/stellent/groups/dft_rdsafety/documents/pdf/dft_rdsafety_pdf_504644.pdf
	Tomorrow's roads safer for everyone. The first three year review	http://www.dft.gov.uk/stellent/groups/dft_rdsafety/documents/downloadable/dft_rdsafety_028169.pdf
	Promoting a safe environment: Road Safet Initiative 2004–2007 (Isle of Mann)	www.gov.im/lib/news/transport/roadsafety.xml
	Road Safety Strategy for Wales	http://www.wales.gov.uk/subitransport/content/road-safety-e.pdf
	Road safety strategy for Wales. Executive summary	http://www.wales.gov.uk/subitransport/content/road-safety-summary-e.pdf
USA	National strategies for advancing child pedestrian safety	http://safety.fhwa.dot.gov/ped_bike/docs/child_safety.pdf
	National strategies for advancing bicycle safety, June 2001	http://www.nhtsa.dot.gov/people/injury/pedbimot/bike/bicycle_safety/index.htm
Asia and the Pacific	Guidelines on road safety action plans and programmes	http://www.unescap.org/ttdw/Publications/TIS_pubs/Pub_1996/pub_1996_fulltext.pdf
European Union	European Road Safety Action Programme. Communication from the commission	http://europa.eu.int/comm/transport/road/library/rsap/
	Priorities in EU road safety progress report and ranking of actions	http://europa.eu.int/eur-lex/en/com/cnc/2000/com2000_0125en01.pdf
	Consultation paper on the 3rd Road Safety Action Plan 2002–2010: a partnership for safety	http://europa.eu.int/comm/transport/library/strat-version-def.pdf
	White paper: European transport policy for 2010: time to decide.	http://europa.eu.int/comm/energy_transport/library/lb_texte_complet_en.pdf
	European Road Safety Action Programme; saving 20 000 lives on our roads. A shared responsibility 2003 ³	http://europa.eu.int/comm/transport/road/library/rsap/rsap_en.pdf
	European road safety charter	http://europa.eu.int/comm/transport/roadsafety/charter_en.htm
South-East Asia	ASEAN Transport Action Plan 2005–2010	http://www.aseansec.org/16596.htm
Other unintentional injuries		
Australia	National Injury Prevention Plan: priorities for 2001–2003	http://www.dhs.vic.gov.au/nphp/publications/sipp/prev_plan.pdf
	National Injury Prevention Plan: Priorities for 2001–2003 Implementation plan	http://www.dhs.vic.gov.au/nphp/publications/sipp/imp_plan.pdf
	Management policy to reduce fall injury among older people. Policy in brief 2003–2007	http://www.health.nsw.gov.au/publications/pdf/fallsinjury_brief.pdf

	Western Australia Water Safety Strategic Framework 2004–2007	http://www.population.health.wa.gov.au/gov.au/Promotion/Resources/Western%20Australian%20Water%20Safety%20Framework%202004-2007.pdf
Canada	Falls Prevention Initiative 2000–2004 http://www.phac-aspc.gc	http://www.phac-aspc.gc.ca/seniors-aines/pubs/Falls_Prevention/falls_funded_projects/pdf/hvac_fundedprojects_e.pdf
	North Okanagan Falls Prevention Program. Home Safety Check Program 2005	http://www.socialplanning.ca/seniors/falls/home_safety_check_2005/index.html
	British Columbia – Injury free. The Provincial Injury Prevention Plan for Children and Youth	http://www.healthservices.gov.bc.ca/prevent/pdf/bcif.pdf
Norway	Plan of action for 1997–2002 Prevention of injuries at home, school and recreation	http://odin.dep.no/hod/engelsk/publ/handlingsplaner/030005-990513/index-dok000-b-n-a.htm
USA	Adolescent Health Plan: unintentional injury among adolescents (Alaska)	http://www.hss.state.ak.us/dbh/prevention/publications/resiliency/update_UIAA.pdf
Central and Eastern Europe	Childhood injuries, a priority area for the transition countries of Central and eastern Europe and the Newly Independent States	http://www.lshmt.ac.uk/ecohost/injuries.pdf
<i>Intentional injuries (violence)</i>		
Brazil	Plano nacional de prevenção da violência, 2004–2007 [National plan for the prevention of violence]	
Canada	Violence Prevention Initiative Action Plan 2002–2003 (Newfoundland/Labrador)	http://www.gov.nf.ca/vpi/pdf/Ap2003.pdf
Honduras	Plan nacional 2001–2005 para el abordaje de la violencia social en Honduras [National plan to tackle social violence in Honduras 2001– 2005]	
Indonesia	Action Plan for Preventing Ethnic Violence	http://www.cfr.org/pub3217/cfr/cpa_action_plan_for_preventing_ethnic_violence_in_indonesia.php
Jamaica	Citizen Security and Justice Program	http://www.iadb.org/exr/doc98/apr/ja1344E.pdf
	A global approach to crime and violence in Jamaica	http://econwpa.wustl.edu:8089/eps/dev/papers/0410/0410007.pdf
	Violence Prevention Strategic Plan for Jamaica	
South Africa	Intersectoral report on non-natural deaths in South Africa: extent and preventive measures	
	Plan of Action: Violence Prevention and Intervention	
<i>Violence in the workplace</i>		
United Kingdom	Violence in the workplace: policy document (Dumfries and Galloway)	http://www.dumfriesandgalloway.police.uk/foi/class_cat/policy/violence_workplace.pdf
<i>Interpersonal violence</i>		
USA	Action Plan for Interpersonal Violence Prevention in Anchorage, Alaska (2003)	http://www.muni.org/jceimages/healthssd/ivp_action_plan_sec_1.pdf
<i>Domestic violence/intimate partner violence</i>		
Australia	Family and domestic violence policy	http://www.dhw.wa.gov.au/homes/manuals/rental/rental_policy_FAMILY.html

	Western Australian Family and Domestic Violence State Strategic Plan	http://www.community.wa.gov.au/NR/rdonlyres/209390A2-76A2-4303-9AB6-61E7DAABE3AF/0/DCDRPTFamilyandDomesticViolenceStateStrategicPlan2004.pdf
	Family violence and sexual assault in Indigenous communities: “walking the talk” (2004)	http://www.aifs.gov.au/acssa/pubs/briefing/b4.html
	2004–05 Second Action Plan Addressing Violence and Safety Issues for Women in the ACT (Australian Capital Territory)	http://www.women.act.gov.au/secondactionplan.pdf
Belgium	Priorités, missions, activités et perspectives de travail (communauté française) [Priorities, missions, activities and work perspectives (Francophone community)]	http://www.egalite.cfwb.be/upload/album/AP_180.pdf
	Plan d'action national contre les violences conjugales 2004–2007 [National action plan against domestic violence 2004–2007]	
Brazil	Programa de Prevenção, Assistência e Combate à Violência Contra a Mulher. Plano Nacional [Interventions for combating violence against women. A national plan] (2003)	https://www.presidencia.gov.br/spmulheres/ct/livro.pdf
Canada	A Domestic Violence Action Plan for Ontario	http://ogov.newswire.ca/ontario/GPOE/2005/03/08/c2227.html?match=&lang=_e.html
	Spousal/partner violence (Nova Scotia) (2004)	http://www.gov.ns.ca/pps/publications/ca_manual/ProsecutionPolicies/SpousalPartnerMay04.pdf
Finland	Prevention of partner and intimate violence	http://www.stm.fi/Resource.phx/publishing/documents/3263/summary_en.htm
Georgia	The action plan on combating violence against women 2000–2002	http://www.womenaid.org/caucasus/antitrafficking/order64eng.htm
Germany	Action plan of the federal government to combat violence against women	http://www.bmfsfj.de/RedaktionBMFSFJ/Broschuerenstelle/Pdf-Anlagen/PRM-5407-Broschue-Aktionsplan-zur-Beka_property=pdf.pdf
Netherlands	Dealing with domestic violence	http://www.justitie.nl/english/Publications/factsheets/dealing_with_domestic_violence.asp
New Zealand	Domestic Violence Act 1995 Process evaluation	http://www.justice.govt.nz/pubs/reports/2000/domestic_eval/
Norway	Action Plan: domestic violence 2004–2007	http://odin.dep.no/filarkiv/227003/Action_plan_domestic_violence_2004_2007.pdf
	Plan d'action. La violence domestique 2004–2007	http://odin.dep.no/filarkiv/227010/Plan_action_la_violence_domestique_2004_2007.pdf
Portugal	II Plano Nacional Contra a Violência Doméstica 2003–2006 [Second national plan against domestic violence, 2003–2006]	http://www.portugal.gov.pt/NR/rdonlyres/585D7521-A65F-4A05-8124-55BCA0DB5B88/0/PNCVDfinal.pdf
United Kingdom	What a waste: the case for an integrated violence against women strategy (2005)	http://www.thewnc.org.uk/pubs/whatawaste.pdf
	Selby District Domestic Violence Action Plan, 2002–2005 (Yorkshire)	http://www.selby.gov.uk/upload/dommviolenceplan.pdf

	Domestic Violence, Crime and Victims Bill (Scotland)	http://www.publications.parliament.uk/pa/ld200304/ldbills/006/2004006.pdf
	Tackling violence at home: the Government's Proposals on domestic violence in Northern Ireland (2003)	http://www.dhsspsni.gov.uk/publications/2003/domestic_violence/domestic_contents.pdf
	Response to "Tackling violence at home". The Government's proposals on domestic violence in Northern Ireland (2003)	http://www.dhsspsni.gov.uk/publications/2003/domestic_violence/domestic_contents.pdf
	Safety and justice: the Government's proposals on domestic violence (2003)	http://www.eoc.org.uk/PDF/dv.pdf
	Domestic Violence, Crime and Victims Act 2004	http://www.legislation.hmso.gov.uk/acts/acts2004/20040028.htm
	Innovative strategies to provide housing for battered women (1999)	http://www.vawnet.org/NRCDDV/Publications/BCSDV/Papers/BCS2_IS.pdf
USA	Model domestic violence policy for counties (New York) (1998)	http://www.opdv.state.ny.us/coordination/model_policy/index.html
	Domestic Violence Court Action Plan (2004)	http://www.flcourts.org/gen_public/family/bin/dvcourtactionplan.pdf
Sexual violence		
Brazil	Plano nacional de enfrentamento da violência sexual infanto-juvenil [National plan to fight child sexual abuse] (2002)	http://www.mj.gov.br/sedh/ct/conanda/plano_nacional.pdf
New Zealand	Action plan to reduce community violence and sexual violence	http://www.nzips.govt.nz/priorities/assault.html
Youth violence		
Finland	Connect fi 006 proposal for an action plan to tackle violence at school in Europe	http://www.health.fi/connect/activities/proposal.pdf
USA	The Boston Strategy to prevent youth violence	http://www.bostonstrategy.com
Violence against children		
USA	Safe from the start: reducing children's exposure to violence (California)	http://www.safefromthestart.org/pdfs/promisingStrategies.pdf
	Safe from the start: taking action on children exposed to violence (California) (2000)	http://www.ncjrs.org/pdffiles1/ojdp/182789.pdf
	Taking action early to prevent violence (California)	http://www.preventioninstitute.org/firststeps.html
Suicide		
Australia	ACT Youth Suicide Prevention Strategy 1998–2001 (1998)	http://health.act.gov.au/c/health?a=sendsendfile&ft=p&fid=1073872244&sid=
	Reducing suicide: the Queensland Government Suicide Prevention Strategy 2003–2008	http://www.health.qld.gov.au/mental_hlth/publications/20769.pdf
	Reducing Suicide: Action Plan 2003 (Queensland)	http://www.health.qld.gov.au/mental_hlth/publications/20768.pdf
Canada	A summary of national, state and provincial strategies for the prevention of suicide	http://www.suicideinfo.ca/csp/assets/SummaryofNationalStateandProvStrategies.pdf
United Kingdom	National Suicide Prevention Strategy for England (2002)	http://www.dh.gov.uk/assetRoot/04/01/95/48/04019548.pdf
USA	National Strategy for Suicide Prevention: goals and objectives for action (2001)	http://media.shs.net/ken/pdf/SMA01-3517/SMA01-3517.pdf
	Summary of National Strategy for Suicide Prevention: goals and objectives for action (2001)	http://www.sprc.org/library/nsspsummary.pdf

<i>Public health policy (with violence and injury components)</i>		
Australia	Building a better future for young Territorians (Australia)	http://www.nt.gov.au/dcm/youth_affairs/pdf/brochure_youth_policy_framework.pdf
Finland	A Safer Community: Internal Security Programme. Summary (2004)	http://www.intermin.fi/intermin/images.nsf/files/7E16BE52F11364AEC2256F47002D6874/\$file/internal_security_programme_summary_en.pdf
Indonesia	Indonesia National Plan of Action: Follow-up of the Fourth World Conference on Women Beijing (1995)	http://www.un.org/documents/ga/conf177/natrep/nap1996-indonesi.htm
Latvia	Latvia National Action Plan for Reduction of Poverty and Social Exclusion (2004–2006)	http://europa.eu.int/comm/employment_social/soc-prot/soc-incl/nap_incl_2004_lv_en_version.pdf
South Africa	Strategic priorities for the national health system 2004–2009 (2004)	http://www.doh.gov.za/docs/policy/stratpriorities.pdf
United Kingdom	Minding our health: a draft strategy for promoting mental and emotional health in Northern Ireland.	http://www.dhsspsni.gov.uk/publications/old2000/mohstrategy.pdf
	Saving lives: our healthier nation. A white paper (1999)	http://www.archive.official-documents.co.uk/document/cm43/4386/4386/4386.htm
	Statement of policies and procedures on anti-social behaviour	http://www.hullcc.gov.uk/housing/managing/download/asb_policy_documentv1.pdf
USA	Investing in adolescent health: a social imperative for California's future. A strategic plan (2000)	http://www.californiateenhealth.org/download/sp.pdf
	Healthy People 2000. Review 1994 National Health Promotion and Disease Prevention Objectives	http://www.cdc.gov/nchs/data/hp2000/hp2k94.pdf
	Healthy People 2010. Understanding and improving health	http://www.healthypeople.gov/document/pdf/uih/2010uih.pdf

- 1 This document is also available in French at <http://www.preventiondesblessuresstrategie.ca/downloads/elaboration.pdf>
- 2 This document is also available in French at <http://www.preventiondesblessures-strategie.ca/downloads/manuel.pdf>
- 3 This document is also available in French, Portuguese Spanish and other European languages at http://europa.eu.int/comm/transport/road/roadsafety/rsap/index_en.htm

Annex 2.

World health Assembly resolutions

FIFTY-SIXTH WORLD HEALTH ASSEMBLY

WHA56.24

Agenda item 14.15

28 May 2003

**Implementing the recommendations of the
*World report on violence and health***

The Fifty-sixth World Health Assembly,

Recalling resolution WHA49.25, which declared violence a leading worldwide public health problem, and resolution WHA50.19, which endorsed and requested continued development of the WHO plan of action for a science-based public health approach to violence prevention and health;

Noting that a meeting of bodies of the United Nations system on collaboration for the prevention of interpersonal violence (Geneva, 15–16 November 2001) invited WHO to facilitate a better coordinated response to interpersonal violence, as a result of which WHO published the *Guide to United Nations resources and activities for the prevention of interpersonal violence*

Recalling that WHO is a core partner, with UNICEF and the Office of the United Nations High Commissioner for Human Rights, of a working group to support the United Nations Study on Violence against Children, and that WHO is active in the prevention of violence against young people, women, the disabled and the elderly;

Recognizing that the prevention of violence is a prerequisite of human security and dignity and that urgent action by governments is needed to prevent all forms of violence and reduce their consequences for health and for socioeconomic development;

Noting that the *World report on violence and health* provides an up-to-date description of the impact of violence on public health, reviews its determinants and effective interventions, and makes recommendations for public health policy and programmes,

- I. TAKES NOTE of the nine recommendations for prevention of violence contained in the *World report on violence and health* and set out in the Annex to this resolution, and encourages Member States to consider adopting them;

2. URGES Member States to promote the *World report on violence and health* and actively to make use of the conclusions and recommendations of the report to improve activities to prevent and expose instances of violence, and to provide medical, psychological, social and legal assistance and rehabilitation for persons suffering as a result of violence;
3. ENCOURAGES all Member States that have not already done so to appoint within the ministry of health a focal point for the prevention of violence;
4. ENCOURAGES Member States to prepare in due time a report on violence and violence prevention that describes the magnitude of the problem, the risk factors, current efforts to prevent violence, and future action to encourage a multisectoral response;
5. REQUESTS the Director-General:
 - (1) to cooperate with Member States in establishing science-based public health policies and programmes for the implementation of measures to prevent violence and to mitigate its consequences at individual and societal levels;
 - (2) to encourage urgent research to support evidence-based approaches for prevention of violence and mitigation of its consequences at individual, family and societal levels, particularly research on multilevel risk factors for violence, and evaluation of model prevention programmes;
 - (3) in collaboration with other organizations of the United Nations system and other international agencies, to continue work on integrating a science-based public health approach to violence prevention into other major global prevention initiatives;
 - (4) using the resources available and benefiting from opportunities for cooperation:
 - (a) to support and coordinate efforts to draw up or revise normative documents and guidelines for prevention policy and programmes, as appropriate;
 - (b) to provide technical support for strengthening of trauma and care services to survivors or victims of violence;
 - (c) to continue advocating the adoption and expansion of a public health response to all forms of violence;
 - (d) to establish networks to promote the integrated prevention of violence and injuries;
6. FURTHER REQUESTS the Director-General to report to the Fifty-eighth World Health Assembly, through the Executive Board, on progress towards implementing the *World report on violence and health*.

ANNEX

RECOMMENDATIONS FOR THE PREVENTION OF VIOLENCE

1. Create, implement and monitor a national action plan for violence prevention.
2. Enhance capacity for collecting data on violence.
3. Define priorities for, and support research on, the causes, consequences, costs and prevention of violence.
4. Promote primary prevention responses.
5. Strengthen responses for victims of violence.
6. Integrate violence prevention into social and educational policies, and thereby promote gender and social equality.
7. Increase collaboration and exchange of information on violence prevention.
8. Promote and monitor adherence to international treaties, laws and other mechanisms to protect human rights.
9. Seek practical, internationally agreed responses to the global drugs trade and the global arms trade.

Tenth plenary meeting, 28 May 2003
A56/VR/10

FIFTY-SEVENTH WORLD HEALTH ASSEMBLY
Agenda item 12.7 22 May 2004**WHA57.10****Resolution adopted by the World Health Assembly**
57.10. Road safety and health

The Fifty-seventh World Health Assembly,

Recalling resolution WHA27.59 (1974), which noted that road traffic accidents caused extensive and serious public health problems, that coordinated international efforts were required, and that WHO should provide leadership to Member States;

Having considered the report on road safety and health¹;

Welcoming United Nations General Assembly resolution 58/9 on the global road-safety crisis;

Noting with appreciation the adoption of resolution 58/289 by the United Nations General Assembly inviting WHO to act as a coordinator on road safety issues within the United Nations system, drawing upon expertise from the United Nations regional commissions;

Recognizing the tremendous global burden of mortality resulting from road traffic crashes, 90% of which occur in low- and middle-income countries;

Acknowledging that every road user must take the responsibility to travel safely and respect traffic laws and regulations;

Recognizing that road traffic injuries constitute a major but neglected public health problem that has significant consequences in terms of mortality and morbidity and considerable social and economic costs, and that in the absence of urgent action this problem is expected to worsen;

Further recognizing that a multisectoral approach is required successfully to address this problem, and that evidence-based interventions exist for reducing the impact of road traffic injuries;

Noting the large number of activities on the occasion of World Health Day 2004, in particular, the launch of the first world report on traffic injury prevention,²

- I. CONSIDERS that the public health sector and other sectors – government and civil society alike – should actively participate in programmes for the prevention of road traffic injury through injury surveillance and data collection, research on risk factors of road traffic injuries, implementation and evaluation of interventions for reducing road traffic injuries, provision of pre-hospital and trauma care and mental-health support for traffic-injury victims, and advocacy for prevention of road traffic injuries;

2. URGES Member States, particularly those which bear a large proportion of the burden of road traffic injuries, to mobilize their public-health sectors by appointing focal points for prevention and mitigation of the adverse consequences of road crashes who would coordinate the public-health response in terms of epidemiology, prevention and advocacy, and liaise with other sectors;

1 Document A57/10

2 *World report on road traffic injury prevention*

3. ACCEPTS the invitation by the United Nations General Assembly for WHO to act as a coordinator on road safety issues within the United Nations system, working in close collaboration with the United Nations regional commissions;
4. RECOMMENDS Member States:
 - (1) to integrate traffic injuries prevention into public health programmes;
 - (2) to assess the national situation concerning the burden of road traffic injury, and to assure that the resources available are commensurate with the extent of the problem;
 - (3) if they have not yet done so, to prepare and implement a national strategy on prevention of road traffic injury and appropriate action plans;
 - (4) to establish government leadership in road safety, including designating a single agency or focal point for road safety or through another effective mechanism according to the national context;
 - (5) to facilitate multisectoral collaboration between different ministries and sectors, including private transportation companies, communities and civil society;
 - (6) to strengthen emergency and rehabilitation services;
 - (7) to raise awareness about risk factors in particular the effects of alcohol abuse, psychoactive drugs and the use of mobile phones while driving;
 - (8) to take specific measures to prevent and control mortality and morbidity due to road traffic crashes, and to evaluate the impact of such measures;
 - (9) to enforce existing traffic laws and regulations, and to work with schools, employers and other organizations to promote road-safety education to drivers and pedestrians alike;
 - (10) to use the forthcoming world report on traffic injury prevention as a tool to plan and implement appropriate strategies for prevention of road traffic injury;
 - (11) to ensure that ministries of health are involved in the framing of policy on the prevention of road traffic injuries;
 - (12) especially developing countries, to legislate and strictly enforce wearing of crash helmets by motorcyclists and pillion riders, and to make mandatory both provision of seat belts by automobile manufacturers and wearing of seat belts by drivers;
 - (13) explore the possibilities to increase funding for road safety, including through the creation of a fund;

5. REQUESTS the Director-General:

- (1) to collaborate with Member States in establishing science-based public health policies and programmes for implementation of measures to prevent road traffic injuries and mitigate their consequences;
- (2) to encourage research to support evidence-based approaches for prevention of road traffic injuries and mitigation of their consequences;
- (3) to facilitate the adaptation of effective measures to prevent traffic injury that can be applied in local communities;
- (4) to provide technical support for strengthening systems of prehospital and trauma care for victims of road traffic crashes;
- (5) to collaborate with Member States, organizations of the United Nations system, and nongovernmental organizations in order to develop capacity for injury prevention;
- (6) to maintain and strengthen efforts to raise awareness of the magnitude and prevention of road traffic injuries;
- (7) to organize regular meetings of experts to exchange information and build capacity;
- (8) to report progress made on the promotion of road safety and traffic injury prevention in Member States to the Sixtieth World Health Assembly in May 2007.

Eighth plenary meeting
22 May 2004 A57/VR/8

Annex 3.

Interventions to prevent violence and injury

Road traffic injuries

The list of preventive measures for reducing road traffic injuries given below is not intended to be exhaustive; it is based on the *World report on road traffic injuries prevention (1)*.

I. Managing exposure to risk through transport and land-use policies

Reducing motor vehicle traffic

- Efficient land use
- Safety impact assessments of transport and land-use plans
- Providing shorter, safer routes
- Trip reduction measures

Encouraging use of safer modes of travel

Minimizing exposure to high-risk scenarios

- Restricting access to different parts of the road network
- Temporary restriction on access to the road network to professional vehicles (e.g. restrict trucks during weekends)
- Giving priority to higher occupancy vehicles on the road network
- Restrictions on speed and engine performance of motorized two-wheelers
- Restrictions on speed and engine performance of cars, trucks and buses
- Increasing the legal age for use of motorized two-wheelers
- Graduated driver licensing systems
- Control of driver licensing procedures for general population (e.g. controls on bought licenses)
- Control of driver licensing procedures for professional drivers
- Control of vehicles authorized for sale (e.g. imported second-hand vehicles)
- Regular and mandatory service of professional vehicles
- Regular and mandatory service of private car and motorcycles

2. Shaping the road network for road injury prevention

Safety-awareness in planning road networks

Classifying roads and setting speed limits according to their function

Incorporating safety features into road design

Safety features on higher-speed roads

Safety features on single-lane carriageways

Safety features on residential access roads

Area-wide urban safety management

Safer routes for pedestrians and cyclists

Traffic-calming measures

Safety audit procedures (for new transport projects, new road schemes)

Crash-protective roadsides (trees, poles, road signs)

Crash cushions on rigid roadside hazards (e.g. bridges, piers, barrier terminals)

Remedial action at high-risk crash sites (correcting faults in planning/design)

3. Providing visible, crash-protective, “smart” vehicles

Improving the visibility of vehicles

Daytime running lights for cars

High-mounted stop lamps in cars

Daytime running lights for motorized two-wheelers

Improving the visibility of non-motorized vehicles and pedestrians

Crash-protective vehicle design (i.e. secondary safety, passive safety)

Safer car fronts to protect pedestrians and cyclists (in terms of shape, stiffness)

Safer bus and truck fronts (including vans and pick-up trucks)

Car occupant protection

Frontal and side impact protection.

Occupant restraints (e.g. seat-belts, air bags)

Protection against roadside objects (in the vehicles)

Vehicle-to-vehicle compatibility (e.g. between cars and trucks, and sports vehicles, light trucks and passenger cars)

Front, rear and side under-run guards on trucks

Design of non-motorized vehicles (e.g. bicycles)

“Intelligent” vehicles (technology-driven)

“Smart”, audible seat-belt reminders (visible and audible devices)

Speed adaptation or intelligent speed adaptation (ISA)

Alcohol interlocks (e.g. alcohol ignition interlocks, automatic control systems)
 On-board electronic stability programmes (adapted to weather conditions, e.g. ice, snow)

4. Setting and securing compliance with key road safety rules

Setting and enforcing speed limits (good enforcement)

Speed enforcement on rural roads
 Speed cameras (photographic evidence that is admissible in a law court)
 Speed limiters in heavy goods and public transport vehicles (to limit maximum driving speed)
 Black boxes in professional vehicles to record speed data

Setting and enforcing alcohol impairment laws

Blood and alcohol concentration limits (BAC) for the general driving population
 Lower blood alcohol concentration limits for young or inexperienced drivers
 Minimum drinking-age laws
 Deterring excess alcohol offenders
 Random breath-testing and sobriety checkpoints
 Penalties for excess alcohol offenders
 Interventions for high-risk offenders (BAC > 0.15 g/dl)
 Mass media campaigns
 Development of non-repressive strategies for non-drink-driving practices (designated drivers)

Setting and enforcing medical and recreational drugs impairment laws

Mandatory medical control of drivers

Setting and enforcing other road safety rules

Laws and enforcement measures for overloaded vehicles (e.g. goods vehicles, passenger vehicles)
 Setting and enforcing rules related to overtaking
 Setting and enforcing yield right of way rules
 Setting and enforcing other road safety rules (e.g. sign following rules, cameras at traffic lights)

Driver's hours of work in commercial and public transport

Setting and enforcing seat-belt and child restraint use

- Mandatory seat-belt use laws
- Enforcement and publicity
- Incentive programmes
- Mandatory child restraint laws
- Child restraint loan programmes

Setting and enforcing mandatory crash helmet use

- Mandatory laws and enforcement measures on bicycle helmet wearing
- Mandatory laws and enforcement measures on motorcycle helmet wearing

Burns

The list of measures for preventing burns and scalds given below is not intended to be exhaustive; it is based on the World Health Organization/International Society for Burns fact sheet on burns (2).

I. Prevention of fire burns

- Promote the use of smoke detectors and fire sprinklers
- Promote fire-escape systems in residential dwellings
- Promote the use of fire-retardant fabrics for children's sleepwear
- Educate regarding the wearing of loose, flowing garments
- Avoid smoking in bed
- Encourage the use of child-resistant lighters
- Promote the development of fire-safe cigarettes
- Enclose open fires and limit the height of open flames in homes in developing countries
- Promote the use of safer stoves and less hazardous fuels
- Promote the use of less hazardous fuels
- Improve the diagnosis and treatment of epilepsy, particularly in developing countries
- Apply safety regulations to housing designs and materials
- Encourage home inspections
- Promote fire safety education
- Promote introduction of and compliance with industrial safety regulations

2. Prevention of scalds

Lower the temperature in hot water taps

Improve the design of kitchen utensils

Improve the design of stove manufacture devices (e.g. more stable cooking surfaces, devices to protect and prevent access by children)

Promote safety education

Drowning

The list of measures for preventing drowning given below is not intended to be exhaustive; it is largely based on the World Health Organization fact sheet on drowning (3).

1. Remove the hazard

Drain unnecessary accumulations of water (e.g. baths, ponds, buckets, etc.)

2. Create barriers

Build flood control embankments in flood-prone areas

Implement and enforce mandatory isolation fencing for swimming pools

Fence around rural fish ponds, construction ditches (where filled with rainwater)

Fence around other bodies of water around houses and in the community

Encourage fencing around those rural homes in proximity to water (e.g. farmhouses)

Encourage the use of grills over water wells

3. Protect those at risk

Increase swimming and water-safety skills in at risk population

Promote “learn to swim” programs for primary-school children

Increase access to public swimming pools to promote learning to swim

Increase awareness of the need to supervise children both in and outside the home

Establish parent groups or other child-care mechanisms in rural communities

Instruct children to avoid entering fast-flowing streams

Instruct children not to swim alone

Train lifeguards for regular deployment in supervised swimming locations

Harmonize internationally the flags and symbols used for beach safety

Use symbols for beach safety and develop enforcement measures

Educate and/or legislate against consuming alcohol while boating

Educate and/or legislate against consuming alcohol around large bodies of water
Adopt and enforce regulations on drowning safety
Increase education in boat/flight safety regulations
Increase education of the need for personal floatation devices when boating
All boats and larger vessels should be checked regularly for safety, including safety equipment
All boats should never exceed the maximum passenger capacity for which they were designed

4. Counter the damage

Train the general community in resuscitation

Youth violence

The list of measures given here for preventing youth violence is not intended to be exhaustive; it is based on the World report on violence and health (4). Interventions shown in *italics* have been shown to be ineffective in studies in reducing youth violence or the risk factors for youth violence.

I. At individual level

Preventing unintended pregnancies
Increasing access to prenatal and postnatal care
Social development programmes (to reduce antisocial and aggressive behaviour), which might include improving competency and social skills with peers, and promoting behaviour that is positive, friendly and cooperative (e.g. programmes to prevent bullying, conflict resolution)
Pre-school enrichment programmes
Programmes providing information about drug abuse
Providing incentives for youths at high risk for violence to complete secondary schooling
Individual counselling
Probation or parole programmes (e.g. meetings with prison inmates describing prison life/brutality)
Residential programmes in psychiatric or correctional institutions
Academic enrichment programmes
Training in the safe use of guns
Programmes modelled on basic military training (i.e. «boot camps»)
Trying young offenders in adult courts

Providing incentives to pursue courses in higher education
 Vocational training for underprivileged youths and young adults

2. At relationship level

Home visitation (e.g. regular visits by a health-care professional to a child's home)
 Skill training programmes in parenting (e.g. emotional bonds, child-rearing methods, self control)
 Mentoring programmes (i.e. fostering a supportive relationship with a positive adult role model)
 Home-school partnership programmes to promote parental involvement
 Compensatory education, such as adult tutoring
Peer mediation or peer counselling
 Temporary foster care programmes for serious and chronic delinquents
Redirecting youth behaviour (towards conventional activities) and shifting peer group norms
 Family therapy (to improve communications/interactions, solve problems, and to deal with the home environment)
 Programmes to strengthen ties to family and jobs, and to reduce involvement in violent behaviour

3. At community level

Monitoring lead levels and removing toxins from homes (to prevent brain damage)
 Increasing the availability and quality of child-care facilities and pre-school enrichment programmes
 Improving street lighting in at risk poorly lit areas
 Creating safe routes for children/youths on their way to and from school or community activities
 Improving school settings, including teacher practices, school policies and security (e.g. metal detectors)
 Providing after-school programmes to extend adult supervision
 Extracurricular activities (e.g. sports, recreation, art, music, drama, newsletters)
Gang prevention programmes (e.g. suppress gangs, organize communities, provide outreach counselling services)
 Training health-care workers to identify and refer youths at high risk for violence
 Improving emergency response, trauma care and access to health services
 Community/problem-oriented policing (by building community partnerships/solving community problems)
 Reducing the availability of alcohol
"Buying back guns programme" money offered for handing in firearms to the police
 Establishing adult recreational programmes

4. At societal level

Deconcentrating poverty (opportunity to move to neighbourhoods with lower poverty levels)

Activities and policies to mitigate the effects of rapid social change

Reducing income inequality

Reducing media violence

Public information campaigns (to change social norms and promote pro-social behaviour)

Institutional reforms of educational systems

Enforcing laws prohibiting illegal transfers of guns to youths

Promoting safe and secure storage of firearms

Development of «smart» guns (i.e. those that do not function if anyone other than the registered owner uses them)

Strong restrictive licensing law (prohibited except for police officers and security guards)

Bans on guns during specific periods (e.g. weekends after pay-days)

Strengthening and improving police and criminal justice systems

Reforming educational systems

Establishing job creation programmes for the chronically unemployed

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