This document was prepared following the Child Injury Prevention consultation meeting, held on the 31st March and 1st April 2005 at the World Health Organization headquarters in Geneva, Switzerland. The following participants were present:


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Appendices
1. Opening and welcome

The morning session was chaired by Dr Etienne Krug, Director, Department of Injuries and Violence Prevention. He welcomed all the participants, thanked the Netherlands government for its financial support to the meeting, and introduced Dr Catherine Le Galès-Camus, Assistant Director General of Noncommunicable Diseases and Mental Health.

1.1 Opening address by WHO

In her opening speech Dr Catherine Le Galès-Camus, said that this was an important meeting and the first of its kind to "bring together, at a global level, agencies with an interest in child injury prevention to discuss what is being done and to consider some positive directions on what might be done in preventing these injuries and deaths". She stressed that although the burden of deaths, injuries and disabilities in children around the world was enormous, they are definitely preventable. She added that there had been much success documented in high-income countries but the challenge now was to adapt these interventions in poor regions and countries in order to reduce the enormous, unequal burden in these areas. She said that it was important that WHO and UNICEF work together in this area and thanked the UNICEF representatives for their input so far and gave her full support to continued work in this area. She thanked all the participants for taking the time to attend the meeting and wished the meeting well in their deliberations over the two days (full address in Appendix 1).

1.2 Opening address by UNICEF

Mr Morten Giersing, UNICEF representative for Bangladesh welcomed participants on behalf of all his colleagues from UNICEF and thanked WHO for organising this important milestone meeting on child injury prevention. He explained that the decentralised nature of UNICEFs work in countries like Viet Nam and Bangladesh had allowed them to discover child injuries as an emerging health problem through the conduct of community-based surveys. These studies showed that injury, even in poor countries, now constituted such a significant part of overall childhood mortality
and morbidity that UNICEF could no longer afford not to be engaged in this area of work. The realisation that drowning in many countries is clearly a bigger problem than road traffic collisions, was indeed eye-opening. But, it took community surveys to uncover this evidence because of the high mortality of the problem. Verbal autopsy surveys play an important role in gathering data for programming.

Mr Giersing stressed that in dealing with child injuries, we must not forget, that they are not only victims in their own right, but many are made orphans by events robbing the lives of their parents. In Bangladesh, for instance, there are 38,000 such orphans every year.

Over the years there has been strong collaboration between WHO and UNICEF on many fronts related to child survival. Such a union is required for child injury prevention in order to put the topic on the global health agenda. Mr Giersing stressed that together we can work towards eradicating the notion that child injuries are “accidental” because we know from evidence from industrialised countries that many of these injuries can be prevented.

He concluded by thanking The Alliance for Safe Children for its support to UNICEF in the Asia region and for carrying out the large-scale mortality surveys that highlighted this important problem in the area.

1.3 Introduction of participants

Each participant introduced him or herself and the organisation that they were representing (list of participants in Appendix 2).

1.4 Adoption of agenda

Dr Krug introduced the agenda and the objectives for the meeting, which were:
- To outline the current situation in child injuries
- To establish potential areas for effort and collaboration
- To develop a WHO child injury prevention strategy
• To discuss the rationale, concepts and process for developing a *World report on child injury prevention*.

The agenda was adopted (final agenda in Appendix 3).

1.5 **Keynote address**

The keynote address, entitled *Child Injury and Prevention*, was given by Dr Christine Branche – Director of the Division of Unintentional Injury Prevention in the National Center for Injury Prevention and Control (NCIPC) at the Centers for Disease Control and Prevention in Atlanta, Georgia – in the absence of Dr Ileana Arias the Director of NCIPC who was unable to attend. In her address she highlighted the situation of child injuries in the USA, which despite considerable efforts, still looses 20 children a day to injuries. Unintentional injuries and child abuse and neglect were still significant problems in the country. Strategies such as child restraints, smoke alarm systems, counselling at checkups and bicycle helmets have been found to be cost effective and need to be implemented in all States. In addition, CDC are currently developing models for supervision of children which when implemented could save many children from the trauma of abuse, neglect and maltreatment. She emphasised the need to concentrate on education, environmental modifications, enactment and enforcement of safety laws and, where possible use of economic incentives to improve safety compliance (full presentation is attached in the Appendix 4).

2. **The current situation in child injury**

The afternoon session was chaired by Dr Christian Voumard, UNICEF Representative, China.

2.1 **Child injuries around the world – what do we know?**

Dr Margie Peden, Coordinator of Unintentional Injury Prevention in the Department of Injuries and Violence Prevention, presented WHO Global Burden of Disease data that showed that nearly 710,000 children died of injuries in 2002. The majority of
these injuries were the result of unintentional causes such as road traffic injuries, drowning and burns. Injuries account for about 6% of the global burden of disease for children under the age of 15 years.

The data presented clearly show that poor children are disproportionately affected: more than 98% of these deaths occur in low- and middle-income countries, particularly Africa, the Eastern Mediterranean region, South Asia and the Western Pacific. However, child injuries in high-income countries are not insignificant and also show a distinct social gradient in these settings.

Data on morbidity and disability are poor, however, the Global Burden of Disease study (GBD) indicates that 26.6% of the disability adjusted life years lost are among children under the age of 15 years. The actual number of children injured non-fatally and requiring medical attention is unknown, but in high-income countries this number appears to be in the range of 50 million emergency room visits and 4 million hospital admissions a year.

All children are at risk, but environmental hazards such as the traffic mix, uncovered wells, large open bodies of water, crop spraying, open fires, etc are particular to low- and middle-income countries and about which we have little or no information. These different situations will require different solutions.

There are a number of gaps in the data. For instance, not all countries report their vital registration data to WHO (in fact very few low- and middle-income countries do so) and therefore the global data are modelled on a limited number of countries. Even for information from high-income countries – injury specific data are flawed. For instance, burns data does not include scalds, drowning does not include floods, etc. In addition, the presentation of GBD is in aggregate age groupings which makes the analysis of injuries to children under the age of 19 years difficult. Finally, there is little or none global data on the cost of injuries to families, society and countries, and even less on the cost effectiveness of interventions. Access to medical care, particularly for children in developing countries, is not routinely collected.
This presentation highlighted some of the current deficiencies in WHO’s child injury data and suggested areas where this could be improved in order to give us a better understanding of the true global picture (full presentation is attached in the Appendix 5).

2.2 The regional burden of childhood injuries – data and lack of data

Dr Adnan Hyder from Johns Hopkins University and the President of the International Society for Child and Adolescent Injury Prevention, presented a regional perspective of child injuries, focusing particularly on the Africa and South-Asia regions. He emphasised that some data are available at these levels showing the enormous extent of the problem. For instance, in the sub-Sahara Africa region, seven community-based studies showed between 300,000 and 17 million cases of burns in the sub-region. This large discrepancy in numbers clearly indicates the inconsistency in methods used to assess the problem.

For South-Asia, peer-reviewed articles in the literature revealed that unintentional injuries are estimated to result in the deaths of between 161,000 and 500,000 children under the age of 5 years annually and that this death rate equates to a loss of nearly 11.7 million Healthy Life Years Lost (or 74 healthy life years per 1000 population). Specific information on road traffic deaths in children under the age of 19 years in South Asia revealed that this age group represented between 13-15% of all traffic deaths in the region. The average mortality rate for this age group was 17 per 100,000 population.

A new community-based study from Tanzania, although not specific to children, showed that the overall incidence of injuries in the country was as high as 32.7 per 1000 per year and that 96% of these injuries were unintentional in nature.

Recent articles, published in the Lancet, by the WHO reference epidemiology group on child health revealed that child injuries account for between 2 and 7 per cent of deaths to children under the age of five years in WHO regions (see http://pdf.thelancet.com/pdfdownload?uid=llan.365.9465.primary_research.32638.1&x=x.pdf).
On reflection, Dr Hyder noted that the regional data on child injuries only tells us part of the story. Although more relevant studies should be conducted to provide more pieces of the puzzle (particularly with regard to the impact on the health system), the lack of data should not be an excuse for inaction (full presentation is attached in the Appendix 5).

2.3 Causes of child injury

Dr Kayode Oyegbite, Senior Programme Officer for the Planning and Coordination Health Section at UNICEF headquarters in New York, noted that the major causes of childhood injuries were: road traffic collisions; drowning; violence and assaults; burns including electrocution; poisoning; falls and animal bites.

Road traffic collisions cause approximately 1.2 million deaths per year. Extrapolation from a United States study suggests that an estimated 54 million hospitalizations and 1.56 billion non-fatal injuries require a visit to the emergency room or a hospital. In poor countries, such as Bangladesh, road traffic collisions are the second leading cause of death in children under the age of 18 years and the sixth leading cause of overall death. They are also the fourth leading cause of disability in the country. Likewise, in China, road traffic collisions account for one-third of the injury deaths or 14.2% of the total deaths to children under the age of 18 years.

Drowning causes about half a million deaths per year. The overwhelming majority are among children under the age of 18 years. In Bangladesh and Viet Nam, drowning is the leading cause of child deaths under the age of 9 years.

Dr Oyebite presentation highlighted violence, burns, poisoning and falls as significant causes of death, injury and disability among children. He concluded by suggesting that the focus should be on improving policies for the prevention and treatment of these injuries in all countries around the world, but especially in low- and middle-income countries. Simple tools for the documentation of injuries at a community and system level should be refined. Partners should work together on advocacy, prevention and appropriate treatment (full presentation is attached in the Appendix 5).
3. UNICEF and WHO activities in child injury prevention

3.1 WHO – Work relevant to child injury prevention

Mr Ian Scott, Technical Officer in the Department of Injuries and Violence Prevention at WHO, outlined WHO's current work in the area of child injury prevention. Apart from the Department for Injuries and Violence Prevention, three other departments at headquarters conduct child-related work:

- **Child and Adolescent Health and Development (CAH)** ([http://www.who.int/child-adolescent-health/](http://www.who.int/child-adolescent-health/)) is responsible for interventions concerning the health, growth, and development outcomes for children aged between 0 and 19 years. Their current main areas of work are: the Integrated Management of Childhood Illnesses; child and adolescent Rights; adolescent sexual and reproductive health; and HIV/AIDS. The main objective of this department is to reduce illness and death among children and adolescents; and to improve the health and development of children and adolescents.

- **Protection of the Human Environment (PHE)** is a department within the cluster of Sustainable Development and Healthy Environments. Two units within this department are working on elements of child injury prevention. They are:
  - **The Healthy Environments for Children Initiative** ([http://www.who.int/features/2003/04/en/](http://www.who.int/features/2003/04/en/)). WHO is working with various partners and groups around the world to establish a global alliance to tackle environmental threats to children’s health. The Healthy Environment for Children (HECA) was launched in 2002 at the World Summit on Sustainable Development. By drawing on the strengths of many different parties, HECA aims to mobilize support and intensify global action to make children’s environments safe and healthy places to live, play and learn.
  - **The International Programme on Chemical Safety** ([http://www.who.int/ipcs/en/](http://www.who.int/ipcs/en/)) which was established in 1980, is a joint programme of three Cooperating Organizations – the International Labour Organization, the UN Environmental Programme and WHO. Its main roles are to establish the scientific basis for safe use of chemicals (including safe storage of chemicals to prevent accidental ingestion by children), and to strengthen national capacities for chemical safety.
• Evidence for Information and Policy (EIP) ([http://www3.who.int/whosis/menu.cfm?path=evidence&language=english](http://www3.who.int/whosis/menu.cfm?path=evidence&language=english)). This department conducts all data-related activities: epidemiology and the burden of disease; cost-effectiveness of health care interventions; health systems assessment and reform, including quality of care, ethical issues, financing, resource allocation, regulation and legislation.

Each regional office in WHO (except for the South-East Asia region where a candidate is currently being recruited) has a Regional Advisor who has injury and violence prevention as part of their portfolio.

At headquarters in WHO, the department of Injuries and Violence Prevention (VIP) has, up until now, not focused on child injuries, but rather developed tools and normative documents which are applicable for injury prevention across the life-span. These include: the two World Reports (one on violence prevention and one on road traffic injury prevention); guidelines (injury surveillance, community-based surveys, essential trauma care); factsheets and advocacy tools. In addition, VIP provides direct technical support to countries to develop and implement injury prevention strategies.

As a result of the scaling up of VIPs work in the area of child injuries, with the preparation of the child injury prevention strategy, a new site on the VIP website has been dedicated to child injury prevention ([http://www.who.int/violence_injury_prevention/other_injury/childhood/en/](http://www.who.int/violence_injury_prevention/other_injury/childhood/en/)) This site will be regularly updated (full presentation is attached in the Appendix 6).

3.2 UNICEF Child injury prevention: What have we achieved and where are we?

Dr Huan Linnan, UNICEF regional advisor in the East Asia and Pacific office in Bangkok presented on behalf of her regional colleagues. UNICEF is currently working in 158 countries. It works with multiple sectors including those of health, education, women and childrens’ affairs, child protection and social welfare. Over the last five years, two major events have shaped UNICEF’s work in the area of child injury prevention. These were the publication of the Innocenti research centre study
The East Asia and Pacific (EAP) regional office for UNICEF is particularly active in the area of child injury prevention. The strategies used by this regional office have far reaching effects because the area potentially covers two-thirds of the world’s children. In particular, the EAP regional office has been involved in a number of national and mega city community surveys in collaboration with The Alliance for Safe Children and the governments of Bangladesh, China, Indonesia, Thailand, the Phillipines, and Viet Nam. Other regional activities include: advocacy; coordination and technical support; capacity building for country offices and counterparts; research, programme design and implementation; developing region-wide initiatives; and integrating specific injury prevention activities into child survival strategies.

The community surveys conducted in those six countries provide evidence for advocacy to policy-makers, donors and nongovernmental organizations. They highlight the need for multisectoral collaboration and the usefulness of such data in raising public awareness. Model demonstration sites have been developed. In all countries, the level of child injuries, particularly drowning, is alarming.

UNICEF has also initiated smaller scale projects in Central and Eastern Europe, as well as the Americas and the Caribbean. They plan to develop a major initiative in the Gulf states in the future.

UNICEF believes that addressing child injury is one of the mechanisms required to achieve the Millenium Development Goals and that injury prevention should be integrated into relevant sectors and programmes already in place in countries. It is UNICEF’s vision that “a childhood free from injury is every child’s right” (full presentation is in Appendix 6).
4. Child injury prevention efforts by participating organizations

Each international or regional organisation represented at the meeting was given an opportunity to present their agency, its goals and objectives, and areas of work. In addition, each participant was asked to complete a questionnaire about the focus of their work. The following groups were represented at the meeting:

- Child Accident Prevention Foundation for Southern Africa
- China - Centers for Disease Control
- Centre for Child and Adolescent Health, Bristol, UK
- Department for Transport, UK
- European Child Safety Alliance
- Global Forum for Health Research
- Health Canada, Health Surveillance and Epidemiology Division
- International Society for Child and Adolescent Injury Prevention
- Institute of Child and Mother Health, Bangladesh
- Karolinska Institute, Department of Public Health Sciences
- Klaipedia College, Lithuania
- Monash University Accident Research Centre
- Safe Kids Worldwide
- Suez Canal University, Egypt
- The Alliance for Safe Children
- The Netherlands, Ministry of Health
- The Secretary General's Study on Violence Prevention
- UNICEF
- USAID, Bureau for Global Health
- US Centers for Disease Control and Prevention, National Center for Injury Prevention and Control
- University of Georgia, Department of Health Promotion and Behaviour
- University of Birmingham, Forensic and Family Psychology
- Viet Nam, Ministry of Health
- World Health Organization

A compilation of all questionnaires is included in the Appendix 7.
5. Identification of key areas for support

5.1 Knowing what works

Professor Joan Ozanne-Smith from Monash University Accident Research Centre gave an overview of child injury prevention activities in high-income countries such as Sweden and Australia.

She stressed that injuries are preventable but it is knowing what works in different settings that is complex. Current epidemiological studies indicate that low- and middle-income countries now have child injury death rates that are comparable to those in high-income countries some decades ago and that the worst is predictably still to come in these developing countries.

Professor Smith stressed that, although there is no blue print for child injury prevention globally, certain principles are the mainstay of all successful strategies, including: environmental changes; legislation and enforcement; organizational change; behaviour change; and education, advocacy and economic incentives.

She concluded by calling for a child injury prevention strategy and plan of action that has goals and targets. It should include intersectoral cooperation and foster the development of national and international networks. She concluded by highlighting the urgent need for a trained workforce (even in high-income countries), adequate funding and the need to urgently implement what we already know works (see full presentation is in the Appendix 8).

5.2 Understanding what information we need and how to get it

Dr Christine Branche, Director of the Division of Unintentional Injury Prevention in the National Center for Injury Prevention and Control (NCIPC) at the Centers for Disease Control and Prevention in Atlanta, Georgia, gave a short overview of what information is required for child injury prevention and how these data should be obtained.
She stressed that all interventions be tested prior to implementation - there had been cases where strategies had been implemented in countries before we knew whether they were effective or not, sometimes with disastrous consequences. She suggested that what we need is some type of "clearinghouse" where we could find out who was doing what around the world and the effectiveness of different types of interventions in different settings. In addition, a good network of child injury practitioners would be beneficial so that participants could know what others were doing, and thus did not waste their precious financial resources on duplicative efforts.

Dr Branche stressed that although data were an important part of injury prevention, practitioners, researchers and policy-makers do not need to wait for perfect data before implementing interventions. Each country should collect the data they need for their purposes. Data need not be sophisticated, just consistent.

Countries should build on initiatives and strategies they already have in place, e.g. integrating child injury into child survival policies. They should not reinvent the wheel - low- and middle-income countries can learn from the successes and failures of high-income countries.

5.3 Getting governments and institutions to take note of injury

Ambassador Douglas "Pete" Peterson, Director of The Alliance for Safe Children, gave an overview of how important it is to get government, politicians and donors to take note of the problem of child injuries. He stressed that it was important to convince policy-makers using science-based evidence (both on the magnitude and cost of injuries) but that it was also important that any suggestions made should be practical, political and economical.

Because personalising the problem makes it easier to get the message across, he advised to be informed about the policy-makers before approaching them. Relevant information may include whether they have ever lost anyone to an injury, people they know, and the focus of their work. In addition to personal characteristics, you also need to take into account distinctive features of the country, such as specific cultures and the availability of resources. Incorporating some of this background information
in your presentation will get the attention of the policy-maker immediately. It is also useful to include in your delegation a local champion or representative.

Ambassador Peterson emphasised that when approaching a policy-maker it was important not to narrow your approach down to one issue only, e.g. drowning or road traffic collisions. You need to present the bigger picture and show how child injury is an important piece of the puzzle. The policy-maker needs to understand that by addressing just drowning or traffic collisions they won’t solve all the problems, but it will be a start and leaves the door open for the next person to add their issues to the agenda.

Finally, Ambassador Peterson emphasised that to get policy-makers to hear what you have to say you have to be persistent. You have to make a "nuisance" of yourself so that they associate you with a particular cause. However, you do need to be very careful that you never exaggerate the extent of the problem. You need to maintain credibility, provide all the evidence necessary, and above all be professional when dealing with policy-makers. If you are persistent enough, someone will eventually hear what you have to say.

5.4 Transferring efforts across countries

Mrs Joanne Vincenten from the European Child Safety Alliance outlined a process through which efforts may be transferred across countries. Using her vast experience working across countries in the European Union in child safety, she presented some potential success factors related to outcomes, structure and process.

She emphasised the importance of understanding the target audience, particularly with regard to culture and history; securing political support and, where possible, linking into a larger political process; and using the media as important partners in advocating for cross-country initiatives.

Mrs Vincenten cautioned of possible threats to the transfer of knowledge among countries. Possible drawbacks include the promotion of self interests, turf wars,
communities not ready to accept a new intervention. Likewise if the goals that have been set are not focused and tangible there might be an equally negative outcome.

Finally, she presented some issues to consider with regard to the sustainability of projects that had been transferred from one country to another. These included the monitoring and adjusting of outcome goals and objectives on a regular basis. She stressed that it was important to have enough resources to sustain the project through to the end.

The transfer of experiences in child injury prevention from one country to another requires patience and persistent effort, taking into account the needs of different countries. But the sharing of experiences is important. Because human and financial capacity are limited, we need to learn from each other and not reinvent the wheel in each country (the full presentation is in the Appendix 8).

6. Development of WHO strategy for child injury prevention

6.1 Draft strategy

Mr Ian Scott, Technical Officer from the Unintentional Injury Prevention team in the Department of Injuries and Violence Prevention, gave a short overview of the draft strategy, which had been prepared in advance of the meeting by a small working group.

The draft strategy presented has six chapters and includes: a global overview; what is missing in child injury prevention; the current role of WHO; the role of other international agencies; the strategic plan and a plan of action; and how this strategy will be implemented. The complete draft strategy is available in the Appendix 9.

Participants were randomly assigned to two groups. Each group was assigned a moderator and asked to deliberate the following questions with regard to the strategy:

- What age groups should be included?
- What injuries should be covered?
- What additions, subtractions should be made to the draft strategic plan?
• How should the strategy be implemented?
• What other partners should be engaged?

The moderators were asked to present their discussions back to the plenary session.

6.2 Report back from two discussion groups

Dr Adnan Hyder moderated group 1. The outcomes of their discussions were:

Age groups:
• The Convention on the Rights of the Child definition is good but need to decide on ending year (18 or 19 years)
• Disaggregated data are needed due to variations in exposure, etc.
  o Along small age ranges
  o Along developmental lines
  o Suggestion: 0-1, 1-4, 5-9, 10-14, 15-17 and 15-19
• Reporting can account for age distributions
• Need to recognize different roles by age in different cultures
• Terminology includes "adolescents".

Which injuries:
• All - balanced report in terms of intentional and unintentional (high burden)
  o Common risk factors
• Need to ensure that we do not duplicate what was published in World report on violence and health and the current UN child abuse study that is being written
• Need to address the grey area between intentional and unintentional injuries
  o Negligence and neglect
• Injuries should be included by sector: where children live (home), where they learn (school), where they play (community, environment)
• Injuries should also be disaggregated by diagnosis (fracture versus head injury)
• Include
  o Animal and snake bites
  o Occupational injuries because child labour an issue in LMICs
  o Product-related injuries
• Long-term effects

• Exclude
  o Medical errors
  o Lead poisoning

• No consensus was reached on the inclusion of
  o Forms of violence that do not result in physical injuries
  o Mental health violence

Comments on the strategic plan:
Participants asked for clarification on who was going to implement the plan because this would influence how the plan was developed. It was agreed that it needed to be multisectoral. That WHO would engage as many partners as possible to implement the strategy with them. Participants suggested that it would be useful to develop a matrix of how different roles, injury types and sectors can contribute. Professor Ozanne-Smith agreed to develop such a matrix.

Participants thought the following points were weak or missing from the draft strategy and so needed to be added:

• Describe child development in relation to risks
• Explain the impact of children living in a world made for adults
• Define the role of WHO in the strategy very well
• Focus on the comparative advantage of WHO
• Provide data for making the case to Ministers of Health
• Include the cost of child injuries
• Highlight inequalities between and within countries and among vulnerable children
• Strengthen the whole health systems and services component of the strategy
• Add realistic time scales
• Explain capacity development and human resources
• Discuss the role of the media and communication of the strategy
• Mention the role of NGOs
• Include research of causal and risk factors, improved legislation and enforcement, and primary and secondary prevention
What other partners could be included:
Participants suggested that the following partners be included in the either the strategy development, implementation or evaluation:

- Health care sector
- Transport sector and other ministries (law enforcement, police, education, women and child welfare, finance, labour)
- NGOs
- Professional associations
- Industry/product safety
- Academia
- Policy-makers, parliamentarians
- Media
- Youth unions
- The children
- Community-based organisations
- Child commissioner
- Donors
- Hospitals and clinicians
- Insurance companies

Implementation of the strategy:
Participants emphasised that the strategy should not only be owned within the health sector, but beyond. They also stated that the messages in the strategy be targeted by audience and have related activities or products. Participants noted that data to back up this strategy were going to be a problem, particularly non-fatal data and health access - the notion of conducting a multi-country or site study was brought up.

Professor LaFlamme moderated group 2. Many suggestions made by group 1 were shared by this group. However, they had the following to add:

Age groups:
- Should include 0 - 18 years
- Age groupings should be: less than 1, 1-4, 5-9, 10-14, 15-18

Which injuries:
Participants emphasised that the description of injuries should be inclusive in terms of diagnoses, severity of level (both morbidity and mortality), and of data sources (e.g. including case studies or small area studies where national data were not available).
Comments on the strategic plan:
Participants highlighted the need for cross-sectoral intervention management as well as the need for a cross ministerial process.
They did not suggest excluding anything from the current draft of the strategy.

What other partners should be included:
In addition to the list presented by group 1, group 2 mentioned global partners, as well as those at a country and community level particularly within the different Ministries. It would also be important to include:

- The Red Cross and Red Crescent
- Scouts
- Universities
- Societies of Paediatrics
- Medical Schools

6.3 Next steps

Ian Scott summarised the input received by the two groups and indicated that this is just the beginning of a process to develop the strategy. The next steps will be to:

- Incorporate changes suggested by the groups
- Circulate a new annotated outline of the strategy to all participants for comment
- Identify a small working group for continued work on the strategy
- Write up the full strategy
- Finalise and publish

The strategy should be finalised for launch at the World Injury Prevention meeting scheduled for April 2006 in Durban, South Africa.

7. World report on child injury prevention

The first morning session was chaired by Dr Loek Hesemans, Department for Nutrition, Health Protection and Prevention, Ministry of Health, The Netherlands.
7.1 Lessons learned from previous reports

Dr Alex Butchart, Coordinator of Violence Prevention and Dr Margie Peden, Coordinator of Unintentional Injury Prevention, presented the differing and similar approaches used to develop the *World report on violence and health* and the *World report on road traffic injury prevention*. They highlighted some of the challenges and constraints as well as the successes of each product. Neither process was flawless and lessons can be learned from each approach used. The challenge for those who will be involved in developing the *Child injury prevention world report* will be to build on these past experiences and try to avoid some of the pitfalls that were encountered with the previous two reports (the full presentations on these two talks are included in the Appendix 10).

Dr Etienne Krug, Director, Injuries and Violence Prevention, WHO, chaired the rest of the day’s proceedings. He lead discussions on the rationale, scope, and process for developing a *World report on child injury prevention*. He posed a number of questions:

- Do we need a world report on child injury prevention?
- If so, what would its added value be?
- What should its goals and objectives be?
- What should its key messages be?
- Who should the report be written for?
- What should the report include?
- How should the document be structured?
- What process should be used to develop the report?

The discussions around these questions are summarised in the following sections.

7.2 Do we need a world report on child injury prevention?

Participants stated that it was critical to write a separate report on child injury prevention because many of the recent reports, most notable the World Health Report
on Maternal and Child Health released on 7 April 2005, do not include this topic. In addition, participants emphasized the importance that WHO and UNICEF jointly develop this report because each organization has unique strengths and address different audiences. Jointly produced, this report would be more powerful than if it were just released by WHO. Both organization should be seen to be putting this issue on the agenda together and talking with one voice.

The only word of caution from participants was to balance resources and efforts in the area of child injury prevention. Developing a World Report is notoriously expensive. Not all the scarce available resources need to be spent on the report.

7.3 What will its added value be?

Participants stated that a World report on child injury prevention will be an important tool for politicians and practitioners alike. The report will demonstrate that child injuries are an integral part of the child health puzzle and that unless child injuries are addressed, particularly among children aged 1 to 4 years, the Millennium Development Goal 4\(^1\) on child mortality is unlikely to be reached.

In addition, the report will hopefully fill some gaps in the literature and indicate where more research is needed. Participants discussed one particularly obscure area, where intentional and unintentional injuries overlap.

Finally, by including different partners and stakeholders, the report will highlight that child injury prevention is a multidisciplinary effort and not just a health issue.

7.4 What should its goals and objectives be?

The following goals were proposed by participants:

- To summarize in one document the current body of knowledge, including peer-review articles and “grey” literature.
- To increase investments in child injury policy

\(^1\) Reduce by two thirds the mortality rate among children under five.
• To increase effort currently being made to fill gaps
• To give visibility at a local level.

Participants indicated that the report should include the following specific objectives:

• Examine child injuries within the spectrum of other child problems and why they are now showing a rise as other childhood diseases decrease

• Highlight the magnitude of the problem
  o Epidemiology of the problem by characteristics of the person (e.g., age and gender of the child, family income), place (e.g., culture, climate, country), and time (e.g., seasonal trends, changes over the past decades, projections for the next decades).
  o Known risk and protective factors for specific groups
  o Costs to the family and society, as well as the cost of doing nothing
  o Gaps in knowledge - this will indicate what needs to be done
  o Outcome of injuries: death, disability, and other health consequences
  o Sources of data (e.g., new data obtained from multi site centres, global data)

• Raise the profile of injury
  o get it on the political agenda
  o get it on the public health agenda
  o get it on the agenda of multiple sectors and ministries

• Highlight the preventability of injuries
  o Injuries are an acute event - some interventions can have immediate effects (low hanging fruit), some take longer
  o Transferability of interventions from HIC to LMIC and across different cultures within countries
  o Some countermeasures that are transferable but the implementation strategies might be different
  o Programme effectiveness versus efficacy
  o Highlight cost effectiveness of interventions
  o Environmental changes
  o Inform policies where childhood injuries are a problem
- Inform programme planners by documenting good practice
- What doesn’t work
- Promote an evaluative approach
- Move from piloting interventions in a sub-area to the whole country - going to scale issues
- Lack of resources for interventions at a country level
- Highlight the issues of continuity of care following the event. Clearly identify primary, secondary, and tertiary prevention strategies.
- Give clear recommendations
  - Describe the mechanisms that need to be in place to implement recommendations
  - Give guidelines on how to implement the report over the next 5 years
- Include
  - The perspective of the child
  - The perspective of practitioners involved in child placement following child abuse, orphaning etc
  - The link between injuries and development - warning to countries
  - Link safety and development

7.5 **What should the key messages be?**

Based on the suggestions from what specific objectives should be included in the report the following key messages were extracted:
- It is a big problem, getting bigger
- It is part of a larger picture of child disease
- It is a problem in both LMICs and HICs, but most of the burden is in LMICs
- It is related to child development, environment issues, etc
- It can be prevented - we know interventions that work
- It is a multisectoral issue
- It is crucial to reach the Millenium Development Goal 4.
7.6 **Who should the report be written for?**

Participants suggested that we take a different approach to writing this report. Instead of starting with the full report and then going on to write a shorter policy piece or summary, they suggested that we start by writing a short "white paper" which outlines the problem and how it is amenable to intervention, why it needs to be addressed, etc. Such a policy document could be used to gain political support and also leverage additional funding from donors. Writing such a piece, will however, be a little tricky because it will need to include evidence, but much of this will not yet have been gathered on the one hand, and on the other hand one doesn’t want to present everything that will be in the World Report because then when the actual report is launched policy-makers will think this is "old news".

However, the advantage of taking this approach will be that we can secure additional buy-in from policy-makers and hopefully donors. It may also assist with the identification of additional information for the report.

The full report will then be written with clinicians, practitioners and researchers in mind with a shorter summary for policy-makers as was done with the previous two reports. However, this child report needs to include input from children (perhaps boxes written by children or pictures) themselves and somehow needs to reach parents of the child (probably in the form of factsheets and posters).

7.7 **What should be included in the report?**

There was general consensus that the report should include all types of injuries to children: intentional and unintentional injuries as well as the "grey" area between the two.

The report will complement documents already published, such as the Violence and Traffic Reports and the UN child abuse document (which will focus more on the rights of the child).
Participants did not come to a consensus on the inclusion of
  o violence that does not necessarily result in physical injuries
  o psychological trauma suffered by children as witnesses to violence/injury of others

Further deliberation on these issues will be undertaken by the advisory and editorial boards once these are put in place.

7.8 **How should the document be structured?**

There was a lot of discussion and debate about how the document should be structured. Suggestions included

- By injury topic
- By age
- By setting

Or a combination of the approaches.

There were pros and cons for each suggestion, but overall participants indicated that the report could include a combination of approaches. Because of the limitations of injury data collection, the epidemiology of injuries need to be discussed separately for each type of injury. In addition, some risk and protective factors, as well as prevention strategies, are specific to certain types of injuries and to certain age groups. On the other hand, global risk (e.g., poverty, alcohol abuse) and protective factors (e.g., supervision, education, environmental modifications) may be highlighted in a separate chapter. A summary of recommendations of prevention strategies by setting may be particularly important for practitioners (e.g., primary care health workers, teachers, park managers, housing authorities) who influence the prevention of multiple types of injuries. Finally, overall more generic recommendations to countries should be made in the last chapter as was done in the previous two reports.

Participants did feel, however, that specific recommendations for each "type" of injury should be included at the end of each chapter, but that overall more generic recommendations to countries should be made in the last chapter as was done in the previous two reports.
7.9 Process for writing the report

Participants stressed that the lessons learned from developing the previous two reports should be heeded. There was no point in trying to invent a whole new process, but participants did call for, where possible, more face-to-face meetings to discuss drafts of the report.

8. Other child injury prevention joint activities

Participants agreed that while the strategy was being drafted and finalised, and preparations were being made to start the process of developing a *World report on child injury prevention* the following should be undertaken jointly:

- A scientific paper for a prestigious journal like the Lancet
  - why child injuries are important
  - how big child injuries are globally
  - what WHO/UNICEF intends to do about the issue
- A World Health Assembly resolution which calls for the development of a strategy and a world report
- Produce a "white paper" or short document for policy-makers and donors
  - Shouldn’t be longer than 5-6 pages and should be widely distributed
  - WHO will take the lead on developing this document and will send it around for consultation in the next month
  - Should be jointly produced by WHO and UNICEF
- Advocate for child injuries
  - Use existing champions and pressure groups
  - Lobby with foreign affairs and development not just health ministries
  - Involve WHO regional focus persons and MoH focal points early
- Conduct some multi-country or site studies on non-fatal outcomes and health seeking information
- Start gathering the "grey" literature and information now - using some of the existing NGOs and initiatives to get this information (also case studies)
• Meet again in late 2005 to finalise the strategy and policy document and discuss next steps.

9. Next steps

The first step would be to get a short report onto the website to highlight that this meeting took place, and then to follow this with the proceedings of the meeting (in two weeks). The "white" paper would be lead by WHO and UNICEF, while the editorial for the Lancet would be lead by Etienne Krug, Adnan Hyder, Kevin Brown and possibly Christine Branche.

WHO will prepare the next draft of the strategy and circulate this to all participants for comment. A small working group will be engaged to guide the final process of the development of the strategy. The strategy will be launched in Durban, in April 2006.

10. Closing

Etienne Krug closed the meeting and thanked all participants for their valuable input and wished them a safe trip home.

Appendices

1. Opening address
2. List of participants
3. Agenda
4. Keynote address
5. Current situation of child injuries
6. WHO and UNICEF activities in child injury prevention
7. Profile of participating organizations
8. Identification of key areas of support
9. The draft WHO child injury prevention strategy
10. Lessons learned from the two previous World Reports