



**World Health Organization**  
**Organisation mondiale de la Santé**

*Department of Injuries and Violence Prevention*  
*Noncommunicable Diseases and Mental Health*

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## **Developing National Policies on Violence and Injury Prevention**

Report of a WHO Meeting  
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## 1. Introduction

Intentional and unintentional injuries are a threat to health in every country of the world. In many instances they are the leading cause of death and morbidity in the middle of the age spectrum. To raise awareness about their dramatic impact on public health, WHO has engaged in an effort to document the extent and causes of the problem and propose ways to deal with it. Consequently, the Department of Injuries and Violence Prevention (VIP) was created in March 2000.

In October 2002 WHO launched the first World Report on Violence and Health. One of the recommendations of the report is to create, implement and monitor national action plans for violence prevention. Currently a similar World report on road traffic injury prevention is in preparation and will be launched on World Health Day in April 2004. Partly triggered by the first World report, WHO has recently received a number of requests for technical guidance from Member States. To determine the best way for WHO to assist countries in the development of National Plans of Action for violence and injury prevention, WHO decided to bring together partners, who have experience in developing policies or action plans related to the prevention of violence and injury, to share and analyse this experience and define future activities.

The **specific objectives of the meeting** were to:

1. Review current experience with developing and implementing national policies and plans on violence and injury prevention, with particular attention to low-and-middle-income countries (LMIC);
2. Define the scope and content of a national policy on violence and injury prevention;
3. Identify the necessary steps to develop such a policy;
4. Determine how countries can move from a national policy to national action;
5. Determine how WHO could most usefully provide guidance to LMIC countries to assist them in developing national policies and/or programmes on violence and injury prevention.

The meeting agenda and list of participants are provided in annexes 7.1 and 7.2. The first day of the meeting was devoted to a review of national efforts to develop policies on violence and injury prevention (sections 2 and 3.1). Through plenary presentations, group work and plenary discussions, the essential steps in developing such a policy and the main points to be addressed in a national policy document were defined (see section 3.2). During the second day of the meeting participants focused their attention on how to move from policy towards action (section 4) and then proposed specific contributions WHO could make to support countries (section 5).

## 2. Review of existing national efforts to prevent violence and injuries

A number of countries have engaged in a national effort to prevent and reduce the consequences of intentional and unintentional injuries. Often a written document provides the basis for action to be taken by the government and non-governmental partners. During the months preceding this meeting 48 national “policy” documents could be identified through a variety of channels (WHO regional and country offices, internet search, personal contacts). Of these documents, 28 address unintentional injuries, 17 violence, two specifically focus on care issues, while only one provides a global framework for violence and injury prevention (Brazil). These documents are named in a variety of ways, such as policy (9), strategy (9), priorities or framework for action (5), strategic plan (4), local or national plan (8), action plan (5), programme (5), project (3). However, the different titles do not necessarily reflect differences in intention or content. It also appears that the same word may be applied in different ways depending on the country. During the meeting the group operated with the following definitions of policy in mind.

### Some definitions of “Policy”

- ⇒ Course or principle of action adopted or proposed by a government (Oxford Dictionary 1991)
- ⇒ A written expression of goals for improving the health situation, the priorities among these goals, and the main directions for attaining them (WHO 1986)
- ⇒ A statement or expression of goals or principle of actions to improve the health situation (WHO/CAH 2002)

In most instances the intention of the policy document is to raise awareness about the magnitude of the problem, based on an analysis of the prevailing situation; to determine ethical and other principles that should guide action; to provide a framework for action; to define institutional responsibilities and sometimes mechanisms of coordination; and to engage a variety of partners. Some policies include a strategic framework, while some of the national plans seem to be policies. For example, the “National policy framework on injury prevention in Sri Lanka” includes six key strategies and declares itself to be a guide for action. In contrast, the German “Action Plan of the Federal Government to Combat Violence against Women” reads like a policy document, delineating a schedule for specific policy change and new policy development.

As intentional and unintentional injuries represent a wide range of different health problems each with a variety of causes and remedies, some countries chose to develop policies or strategies for specific aspects such as suicide, domestic violence, violence against women, road traffic crashes / road safety, violence in schools. A number of countries have developed a comprehensive set of recommendations for injury prevention, mainly referring to unintentional injuries. It is also interesting to note that no policy document on violence prevention could be found in Asia, Africa (with the exception of South Africa and Mozambique), Eastern Europe or the Middle East.

A more in-depth analysis of the available policy documents from Brazil, Sri Lanka, Vietnam, and Mongolia revealed similarities as well as differences. In all four countries the Ministry of Health took the leadership in developing the national policy. Overall between 8 and 10 ministries and 12 to 17 different agencies were involved,

thus indicating the multisectoral nature of the problem and the need for strong coordinating mechanisms. The stated mission or goal differed in its wording although the intent seems similar.

### **Examples of national goals**

**Sri Lanka** An injury free Sri Lanka. Integrating injury prevention into everyday life across home, school, work place and public places, and people actively managing injury risks and living free of injury.

**Vietnam** Securing safety for people's life, government's properties and people's wealth.

**Brazil** Contribute to the quality of life of the population. Reduce the morbimortality due to accidents and violence.

**Mongolia** Decrease the mortality, number of disabled and handicapped people due to injury.

Some of these documents make explicit reference to other policy or strategy documents, to legal instruments and describe guiding principles.

In conclusion, it appears that there is a wide variety in scope and content of national documents that address the problem of unintentional and intentional injuries. Surprisingly, little emphasis seems to be given to preventive interventions, while care is often considered as being part of prevention.

Participants suggested that it would be useful to get further information on the implementation of these policies and the results achieved. It would be very helpful for countries starting to develop policies to learn from these experiences.

## **3. How to develop a national policy on violence and injury prevention**

Participants agreed that the reason for developing a national policy on violence and injury prevention is first and foremost to raise awareness about the problem, so that some action is taken including obtaining resources to address the problem. The process through which the policy is developed is paramount to achieving these objectives. Questions such as - Who should lead the policy development process? What is the role of the Ministry of Health? Who should adopt and endorse the policy? Who is made responsible for implementation? - need to be answered at the outset. In doing so, at least three major approaches are worth considering: a participatory approach, an evidence-based approach and the mobilization of political forces. During the meeting the participants discussed several examples of how this process has been conducted and what type of political endorsement has been sought and obtained.

### **3.1. Experiences from three countries**

Three country presentations on challenges and successes in developing national policies on violence and injury prevention provided fruitful input to the discussion.

#### **Tunisia**

Dr Mohamed Salah Ben Ammar presented his personal experience in drafting a policy to improve emergency medical services in Tunisia. Previously the political willingness to further develop such services had been expressed on several occasions.

A national strategy to develop medical emergency services exists since 1996. In 2002, a group of committed medical practitioners who were concerned about the lack of coordination within emergency services and gaps in quality of services and medical training took the initiative to formulate additional recommendations. They formed a working group that met regularly over a period of several months to draft a strategy to improve the current situation. Once the strategy document was finalised, it was presented to all partners, including political decisions makers, to engage them in the debate and to get their support to implement the strategy. Although the recommendations of the group were well received, they did not gain sufficient political commitment to be implemented. This is an example of a bottom-up approach that despite strong enthusiasm from concerned health professionals failed to convince the political level.

#### ***Lessons learned***

For a bottom-up approach to have a significant effect it is important to identify supporters, opponents, and reasons for their positions in order to develop a marketable package to satisfy all parties involved. In this case the lack of communication between all partners was a major constraint that was not given due consideration.

#### **Thailand**

Dr Paibul Suriyawongpaisal gave a historical background and illustrated some of the trends that have taken place in road traffic injuries in Thailand since the 1980s. Between 1994 and 2000 the number of motor vehicles has almost doubled in Thailand. Traffic crashes have become the second cause of loss of disability-adjusted life years in men, and fifth for women. Between 70 and 80% of the accidents concern motorcyclists, and more than 70% of the injuries are head injuries. Between 1984 and 2002 the rate of road traffic injuries has increased dramatically with a particularly strong peak between 1994 and 1996 at a time of high economic growth (bubble economy).

Dr Paibul then gave an overview of the political system and the system hurdles that have caused the response in Thailand to be inefficient. Action plans to reduce road traffic injuries were implemented and reinforced several times since 1990 with little or no effect. This was mainly due to a lack of clarity and comprehensiveness of the safety measures, a lack of continuity in implementing the plan, the fact that it was not involving the population and mainly based on discipline. The organizational set-up was inefficient, not transparent, with much overlap and a lack of coordination.

A turning point was reached in the past year. This is mainly due to repeated media coverage of the extent and severity of road traffic crashes during two important festival periods since 2001. This raised public concern and pressure and finally led to a more coherent policy response. The government set a clear signal during New Year 2003 launching a campaign to curb road traffic crashes. This was followed by an unprecedented law enforcement campaign ever launched in Thailand. In July a national policy was decided based on the 5 E's: Enforcement, Education and participation, Engineering, Emergency services and Evaluation and monitoring. Dr Paibul believes that the present government, in collaboration with the media, law enforcement agencies, researchers and other partners will advance the policy movement in road traffic injuries.

**Lessons learned**

(1) To get violence and injury prevention onto the political agenda in a meaningful way action must be taken in four areas: research to show the extent of the problem and point to possible solutions; networking among all partners concerned, including non-governmental organisations and academics; ongoing media coverage to raise awareness and increase public pressure; and, pilot projects to demonstrate that there are feasible and effective interventions.

(2) To be able to raise political commitment it may be more effective to address specific problems instead of wanting to tackle injury and violence in general. The final aim may be to develop an overarching policy on injuries and violence prevention. However, a seemingly piecemeal approach, addressing the most urgent or most visible problem first, is more realistic as demonstrated by the example of Thailand. It is also very important to allow politicians to show some early success.

**Vietnam**

Dr Nguyen Thi Hong Tu presented the process of developing a national policy on injury prevention 2002-2010 in Vietnam. The Injury prevention and safe community programme started in 1996 and is funded by SIDA. After an initial pilot study in four districts, an interventional study was developed in seven provinces (1998 to 2001). The results of this study generated ideas for a national policy for accident and injury prevention. The Prime Minister approved the National Policy on Injury Prevention 2002-2010 in December 2001. Main responsibility for implementing the policy was given to the Ministry of Health. Subsequently the national programme on accident and injury prevention 2003-2005 was developed including several sectoral action plans. Priority areas are (1) transportation: preventing road injury especially accidents on high speed roads; (2) work environment: preventing injuries occurring through construction work, mineral exploitation, electricity use; (3) schools: training to improve knowledge and awareness of injury prevention; (4) in the home, community and for children: preventing drowning, burns, falls, poisoning and injuries caused by landmines and other explosives.

Mechanisms to coordinate national and international activities related to accident and injury prevention were established. Vietnam received substantial support in developing the national action plan from WHO, UNICEF, the World Bank, the Asian Development Bank and several research centres (US, Australia). The action plan was presented to 400 participants at the first conference on implementing the national policy on injury prevention. Many activities are currently underway or planned in most of the provinces. In addition, a national board of traffic and injury prevention was established based on the existing national traffic safety committee and programme of injury prevention.

The main challenges are the size of the problem with a great variety of different types of injuries to be prevented and treated; a persistently weak coordination among national ministries and the different sectors that should be involved; and the lack of strong multi-disciplinary and multi-sectoral research to find new solutions. Encouraging recent developments include the creation of a new board on road safety and injury prevention, of a national injury surveillance system and a revised and strengthened approach to create safe communities.

**Lessons learned**

(1) It would be very useful to have internationally recognized and tested strategies on injury and violence prevention that would inform national efforts. (2) Injury problems must be identified and tackled at the community level. To achieve this community participation is

essential at all times during the policy and action plan development process. The concept of Safe communities or safety promotion, similar to health promotion, is very important for developing countries. (3) Finally, injury prevention capacities must be strengthened at the local and national level through training and research. International support (bilateral and multilateral) is essential in this regard.

### **3.2. Essentials steps in developing a policy on violence and injury**

The participants then reviewed and discussed the essential elements that would ensure to some extent that the policy development process is successful in gathering political and professional support. The main conclusions reached during plenary and group discussions are summarised below.

#### **The policy development process**

At the outset the following questions need to receive clear answers. What is the purpose of developing a policy in a given context? What is the added value of developing a policy? What should the scope of the policy be?

Once the purpose and scope of the policy have been decided three steps should be taken.

1. Epidemiological situation analysis: relevant data about the problem should be gathered, analysed and presented in a clear, easily understandable format.
2. Solutions-oriented situation analysis: based on information about the type and extent of unintentional and intentional injuries, possible solutions that have been tested in the country or elsewhere should be described, as well as gaps in knowledge identified.
3. Political mapping: all possible partners who could participate in addressing the problem should be identified, including those who might initially oppose efforts to prevent violence and injuries. A careful analysis should be made of the position and mind set of specific partners in order to design an appropriate approach in mobilizing and involving them.

Further steps in the policy development process then are the following.

- Raise awareness among decision makers, politicians etc. using results from the initial situation analysis; more targeted lobbying with key decision makers and opinion leaders.
- Call a meeting of all relevant public agencies and other partners to officially launch the policy development process.
- Constitute a multisectoral national committee or task force that has the mandate to develop the policy and the legitimacy to formulate it.
- Subsequently create and sustain a policy debate that may take weeks or months before a final draft of the policy is acceptable.
- At the same time also raise awareness among the general public through the mass media to create an understanding that the issue under debate is critical to their ways of life in addition to health and safety.
- Given the fact that several ministries have to collaborate in implementing the policy, and that its impact is dependent on a long-term commitment, it is highly desirable that such a policy be approved at the highest level of government (i.e. Prime Minister), be ratified by Parliament and given a legal basis.

Policy entrepreneurs are essential to start and sustain a policy development process. These are persons who devote themselves to push the development of a policy and its implementation. These agents for social change are usually passionately committed to some aspect of injury prevention and have the capacity to see the bigger picture and to identify the strategic moves needed to engage all partners. Policy entrepreneurs can come from different areas, i.e. health professionals, academics, government employees.

Meeting participants agreed from their experiences that the process of developing a national policy often leads to the creation of a national environment supportive for injury prevention. This change may be a more important outcome than the national policy itself. As violence and injury prevention is by nature a multisectoral and pluridisciplinary issue, the developmental process is essential in creating the commitment of all parties to take action. It should also be kept in mind that the policy-making process is non-linear and not purely scientific.

***What is the role of the health sector?***

Discussions were held around the role of the health sector among all sectors that need to be involved in formulating policies on violence and injury prevention. Given the fact that any policy or strategy to prevent violence and injuries must involve several ministries as well as the private sector, non-governmental organizations and advocacy groups, it is paramount that a clear leadership be defined. The Ministry of Health can take the lead in developing the national policy, but it doesn't always follow that health should take the lead. In some instances the impetus comes, for example, from the Ministry of Works, the Ministry of Transports or the Ministry of Family Affairs. Whoever takes the lead is responsible for involving all potential partners during the development of the national policy.

Participants agreed that the Ministry of Health must take prime responsibility for some issues such as collecting data on health consequences of accidents and violence; making preventive services that are based in the health sector available; providing emergency medical services, care and rehabilitation; training health care providers; preventing the unnecessary drain of limited health care resources; and advocating for action in other sectors.

Depending on the specific context of a country and the problems to be addressed the role of the Ministry of Health could take various forms.

*Leadership role:* In Vietnam the Ministry of Health plays the leading role in domains such as data collection, care and rehabilitation. Other ministries support the health sector through their initiatives. In Australia the Ministry of Health was expected to take the lead, but later on it was decided that the better way to achieve progress was to create a multisectoral national committee.

*Catalytic role:* The Ministry of Health should start and fuel the debate based on data from the health sector and provides evidence on what should be done (research and data collection). For example, in Australia researchers are trying to show politicians the importance of prevention by forecasting the enormous increase in injuries to be expected in 20 years (in particular injuries due to falls in elder people), if nothing is done.

*Coordinating role:* The Ministry of Health could play an essential role in trying to break up institutional barriers between sectors. In Vietnam it has still not been decided

which ministry, Health or Transport and Communications, will play the coordinating role in developing plans of actions for injury prevention.

*Supportive role:* To provide for an interdisciplinary working environment, the role of the health system could be to incorporate health outcome/resources questions into the debate. The Ministry of Health should analyse and delineate the health impact of policies or action plans addressing violence and injury prevention.

### **Content of a policy document**

With regard to the content of a policy document on violence and injury prevention, the main points to be addressed were defined by a working group and agreed upon in the plenary session.

- The time frame of the policy is clearly stated.
- Reference is made, as relevant, to the National constitution, other national policies and strategies, national laws and regulations and international agreements or treaties.
- Basic guiding principles are defined such as human rights, equity, right to a safe environment, economic interests of the state, community involvement, responsibility of individuals.
- The situation analysis includes:
  - Problem analysis (nature, affected groups, how they are affected, different perceptions)
  - Solution analysis (relevance to priority problems, effectiveness, feasibility, potential consequences, gaps in knowledge)
  - Political mapping (who are the key players, the main opponents etc.)
- A mission statement or vision, that must not necessarily be realistic, describes the overarching goal of the policy.
- Objectives should focus on realistic and measurable outcomes.
- Priorities for action are specified in collaboration with all involved parties
- Strategic guidance is provided, for example, in the form of strategic directions, a strategic framework, a set of essential interventions.
- Constraints/limitations and favourable factors for implementation are considered.
- Institutional responsibilities and obligations and coordination mechanisms between ministries and other national entities are defined.
- Finally, monitoring and evaluation of the policy is addressed, and possible ways of securing resources described.

### **Lessons learned in developing policies on child and adolescent health**

Mr Paul Bloem, Child and Adolescent Health and Development, WHO gave an overview of WHO's policy document: *Making Policy Happen, lessons from countries on developing national adolescent health and development policy*. In order to develop the document WHO did an assessment in 4 countries. The report, aimed mainly at WHO staff and WHO consultants working on policy formulation, contains checklists with content areas as well as process questions (i.e. participation of stakeholder, participation of civil society). In preparing the document it became clear that it is more important to create a supportive policy environment around a specific issue rather than to focus on a policy document that will remain on a shelf. There is thus a change within WHO, the focus being more on the developmental process of a policy rather than the polished final version of the document. In most countries laws and legislations addressing adolescents already exist, and some activities are underway.

The role of policy is then to create an overarching environment at the national level for all these fragmented initiatives.

#### **4. Moving from policy towards action**

A national policy or strategy on violence and injury prevention should provide some guidance on possible actions to be taken falling short of a detailed action plan. To do so the breadth of available interventions that have proven to be effective should be examined to determine which strategies are most useful in the national context and given the scope of the policy. These include legal/regulatory measures, primary prevention interventions and provision of care to the injured.

One important issue in addressing violence and injury prevention is that there is not (yet) a standard set of technically sound and effective interventions to be proposed. In some areas there may be some well-tested interventions (i.e. seat belts and helmets preventing injuries in road traffic crashes), but in others there is little evidence to build on (i.e. how best to prevent domestic violence; which type of pre-hospital care reduces morbidity and mortality due to traffic injuries). However, even well-tested interventions may not be equally relevant in all contexts.

Given the patchy knowledge on what works, when and where, how should a sound national policy be developed that can lead to a national action plan? Is it possible at this stage to propose a strategic framework and a set of essential interventions to be implemented in a national programme?

##### **4.1. Defining strategies – choosing interventions**

Dr Alex Butchard presented a conceptual framework that may help in addressing these questions and allow countries to determine a plan of action.

Strategies refer to broad categories of intervention, such as efforts to reduce violence by improving parent-infant relationships, or to prevent road traffic injuries by slowing down vehicles. Interventions refer to specific ways of carrying out a strategy, such as improving parent-infant relationships through parent training and home visitation, or reducing the speed of motor vehicles using speed bumps. Unlike some other conditions, such as polio or measles, where a single vaccination can be applied with a high likelihood of success amongst all populations, violence and injury prevention has yet to identify any universally applicable interventions, although some in the field of road traffic injury (RTI) prevention such as seatbelts and helmets have very broad applicability. This is due both to the relative newness of the field and the strongly contextual nature of the causes and risk factors for injuries and violence, which are an outcome of causes and risk factors at the individual, relationship, community and societal levels.

Therefore, rather than promoting specific interventions, policy guidelines should aim at promoting more general prevention strategies. Strategies are broader than initiatives in that they suggest *what* should be done but not how it should be done. Assuming that it is preferable to recommend strategies rather than interventions, then the question concerns how to decide which strategies to recommend. In answering this

question a number of criteria can be suggested to identify appropriate prevention strategies in a variety of settings and for different types of injuries.

These criteria are:

- **Evidence** – Policy should support proven and promising interventions, and advocate withdrawing support for interventions shown to be ineffective. However, for much of the world there are no effectiveness studies and it is unclear how far findings can be generalised across very different settings.
- **Cost effectiveness** – although it makes economic sense to support only those interventions that save money, some interventions that cost more than they save may be indicated for problems that are particularly disruptive and disturbing of society. In addition, reliable data on cost-effectiveness of interventions in a given context are scarce and should not prevent action from being taken based on best available evidence.
- **Acceptability** – the populations and communities involved in delivering and receiving the prevention programme should agree with the aims, methods and outcomes of the intervention. However, there may be instances where the public threat of allowing a risk to continue demands that the prevention strategy be applied despite community resistance to it.
- **Feasibility** – the strategy should be implementable with existing resources. For instance, prescribing burn reduction through household electrification is impractical in settings that lack an electricity supply infrastructure.
- **Time frame** – policies should be sensitive to the political timetable, which often needs short term successes. It may therefore be useful to group strategies into those with rapid prevention effects that occur within three months of the intervention (e.g. enforcement of laws regulating alcohol sales, installation of traffic calming measures); those where there is moderate delay of between three and 36 months between intervention and effect (e.g. job creation programmes), and those where there is a long delay of 36 months or more (e.g. social development programmes, home visitation and parent training).
- **Measurability** – prevention strategies must be measurable and should have clearly identifiable intermediate outcomes (e.g. percentage of people wearing seat belts, percentage of homes with a functional smoke alarm) and impacts (e.g. rate of motor vehicle occupants injured, rates of fire related burns in the home).

During the discussion following the presentation, participants emphasised the need to take into account the initial situation in a given country to decide which interventions to prioritise. For example, if there is no data yet on injuries, the policy needs to focus on building a surveillance system and not yet on specific interventions. A policy guideline should thus propose a modular approach describing the various elements that need to be in place first before moving to the next step. Overall a policy should propose a range of interventions from primary prevention to care and rehabilitation.

Regarding the evidence base for proposing specific interventions, the World Violence Report gives some good examples. However, the evidence is almost exclusively from high income countries and may thus not be applicable as such in other settings.

## 4.2. Country experiences

To illustrate how policies can be translated into action, examples from several countries were presented and discussed.

### **Brazil**

Dr Eugenia Silveira Rodrigues and Dr Elisabeth Duarte presented some of the initiatives that were taken after the Brazilian policy on violence and injury prevention was officially approved in 2001. The two priorities chosen by the Ministry of Health within this policy are to improve the mortality information system and to reduce injuries and deaths due to road traffic crashes. Data currently available show that homicides are the first cause of violent deaths, followed by road traffic crashes. Based on this and due to the fact that the Brazilian 1998 traffic code points out that security and life preservation are the most important objectives, road traffic injuries were chosen as a top priority. This is a combination of epidemiological evidence and political opportunity.

Five ministries are actively involved in the Project of reduction of the morbidity and mortality due to road traffic crashes: Ministry of Cities, of Health, of Education, of Work and of Transports. Five major cities, representing 14% of the Brazilian population and located in four regions of the country, will implement the project with the objectives:

- To improve road traffic crashes data;
- To know better the victims and local occurrence;
- To stimulate community participation;
- To take safety measures, e.g. pedestrians crossings.

At the federal level the Ministry of Health and PAHO are launching an award for the best road traffic injury prevention initiatives for World Health Day 2004. Many actions are taking place at the state or community level. The government provides funds to support NGO initiatives.

### ***Lessons learned***

The experience in Brazil highlights some of the most important ingredients to translate policy into action:

- Give citizens responsibility in creating solutions to the problem;
- Stimulate NGO collaboration;
- Develop initiatives in schools;
- Promote multisectoral debates;
- Create campaigns and educative material;
- Take into account road traffic injuries in other health programs (e.g. Family Medicine).

### **Germany: the importance of legal interventions to prevent violence**

In Germany, policy development and legal reforms go hand in hand. This has particularly been the case in the area of violence prevention and intervention. In 1999, the “Action Plan of the Federal Government to Combat Violence against Women” was created by Cabinet decision. The Action Plan determines that all policy areas [– not just the Ministries of Justice and for the Family, for example –] should review the instruments available to them, find gaps in protection against violence, and proceed to install reforms that will fill in the gaps.

Law reform is a central focus of the Action Plan. For example, the Plan called for a new civil court procedure that would allow the courts to remove an abuser from the

home for several months. This resulted in passage of the German Violence Protection Act. Within months of its enactment in January of 2002, most states had reformed rules governing the police's responsibility to remove an abuser from the home. This is considered essential to enabling a woman to seek civil court protection.

While the Action Plan is a policy decision, it has been treated like draft of a law itself. It had to jump the hurdles normally reserved for the passage of a law if it was to obtain the consensus it needed nation-wide. The Plan was therefore submitted to both Houses of Parliament for debate. The result was an endorsement from the federal law-making body, including the governments of the individual states. Although not a law, it is binding for the federal government. It also documents a commitment of the German states to protect women from all forms of violence.

The Action Plan has been instrumental in driving change at the federal, state and municipal levels. At each of these levels implementation issues are critically monitored in workgroups involving women's and children's advocacy. The law reforms have become an on-going process as communities analyze and respond to the need and opportunities to coordinate services.

German health law reform has not yet addressed health and violence. This is nothing unusual in Europe. In Germany, it can most likely be ascribed to limitations of federal and state jurisdictions over health care by the autonomy of the health professions and universities, particularly as regards medical care and training. Hence policy units at the federal and state levels have begun seeking alliances with professional health associations, curricular development, health insurance providers and individual clinical settings to sort out, essentially, who is responsible for what policy and practice change. This dialogue should result in a concerted effort to see to it that appropriate reforms will happen. Again, the new legal instruments protecting against violence have contributed to greater awareness about lacking health sector responses. This in turn is leading to attitudinal change among the health professions who are calling for answers and action.

The positive developments in Germany can be directly attributed to what is perhaps the most extraordinary law reform in this area in Europe, the Austrian Violence Prevention Act. The Austrian law came into effect in the late 90s. The drafting phase is noteworthy as it would appear to be the first successful collaboration between women's advocates and government in writing new law in Europe. They jointly drafted the law, created a new public-private advocacy structure and systematically prepared the law's implementation for an entire year before it came into effect. Research-based evaluation and grass roots monitoring of the law have ensured for seven years now a very forceful debate that has reached policy-makers at the heads of government in several countries in Europe. It is fair to say that the Austrian law has propelled joint efforts between community-based advocacy and government to combat violence across the European continent.

#### ***Lessons learned***

A legislative approach that involves community-based advocacy is very useful to propel action on violence and injury prevention. Existing laws should be evaluated and reformed where needed; new laws should be drafted where gaps have been identified. This approach should be an integral part of the initial situation analysis.

Legally binding instruments outside formal law making should be taken into consideration where the legislature or government has passed power to independent bodies that create their own policy or standards of practice. In particular this can be useful in the health field.

### **European efforts to combat violence**

The European Union has not created its own law on violence prevention. There is little likelihood of consensus that the Union per se must set a standard – such as a directive – against which national policy implementation would subsequently be measured. However, the European Union has provided policy-guidance in a number of other ways. From recommendations from the European Parliament to funding – most notably from the European DAPHNE programme to combat violence against children, youths and women. This programme was installed for the years 2000-2003. Its continuation is currently under debate. The legal basis for European spending in this area is an article governing the Union's jurisdiction over public health. This would appear not to have shaped the DAPHNE Programme, however. Only few of the DAPHNE projects conducted have involved health professions. Hence the European Commission explicitly requested in its last call-for-proposals that projects address the health sector. A positive result of this was the founding of the European Violence Prevention in Health Network, which in 2003-2004 will with the help of a DAPHNE grant:

- Conduct the first multi-centre forensic medicine epidemiological study performed in Europe on the prevalence and health effects of violence against women and children;
- Pursue multidisciplinary health intervention in clinical and private practice settings;
- Examine the role forensic physicians can play in different health settings;
- Develop recommendations for Europe (health practice protocols and potentially for law reform) to utilize forensic medical expertise in violence prevention and intervention more effectively; and ultimately
- Establish the basis for a sustainable European Violence Prevention in Health Network.

### **Mongolia**

Ms Pam Albany briefly reported on her experience in assisting the Mongolian government to draft the National programme on injury prevention. Initially the trauma surgeons brought injuries as a priority public health problem to the attention of the government. Violence, traffic crashes and alcohol were identified as the key issues. A deficient infrastructure, certain cultural habits and the very cold weather in winter are additional elements that increase the risk of injuries. Excellent and numerous data were available, but had not been analysed in a coherent fashion. The situation analysis has just been completed and a national committee for injury prevention has been trained. It will be very interesting to follow the implementation of the national programme during the coming years.

### **Australia: strategies to prevent injuries and their consequences**

Ms Pam Albany described the Australian experience with regard to injury prevention. A national injury prevention plan was developed four years ago from the perspective of the health sector. However, this policy was not effective due to a lack of political support and funding. It is likely that the people benefiting most from the programme

are the well educated, and not the most vulnerable groups (poor and remote environments). The national plan is currently being evaluated.

In parallel the Ministry of Transport developed a national policy on road trauma. This policy was successful in reducing road trauma by controlling drink driving, speeding and fatigue. In Australia, suicide is still the first cause of death among all injuries. A more restrictive firearms legislation has achieved a significant decrease in homicides and suicides. The biggest issue facing the Australian health system are injuries due to falls in elderly people. This is already the principal cause of injury-related morbidity and will increase dramatically in the coming years due to the aging of the population.

Currently a discussion paper suggesting priorities for injury prevention for 2004 and beyond is under debate. It highlights the importance of partnerships and focuses primarily on vulnerable population groups (youth, adult, remote, aboriginal) instead of injury categories. It also connects injuries and alcohol abuse.

#### ***Lessons learned***

(1) The public health sector has an important role to play, but must work in conjunction with other Ministries from the beginning to gain wider support and harness more resources. In Australia, the public health sector has had little importance in driving traffic injury prevention and violence prevention. However, it was the driving force in preventing fall injuries and poisoning and in pushing the firearms legislation. The health sector has also been at the forefront of the Safe Community approach.

(2) It is possible that there may at times be a direct competition between for e.g. health and transport policies when addressing the problem of road traffic injuries. This should be avoided by developing a close collaboration at the start.

(3) The driving forces to raise awareness about the importance of unintentional and intentional injuries are trauma surgeons and paediatricians.

## **5. Priority lines of action for WHO**

### **5.1. WHO's role**

There have been several General Assembly resolutions on injury and violence prevention in the past. Following the publication of the World Report on Violence and Health a resolution specifically on violence prevention was passed at the World Health Assembly (WHA) in 2002. Subsequently a guide on how to implement the recommendations of the report has been drafted. Currently WHO is preparing a similar World Report on Road Safety, and is hoping for a WHA resolution on the prevention of road traffic injuries in May 2004.

Dr Etienne Krug then briefly explained WHO's role in injury prevention. Headquarters, regional offices and country offices collaborate to serve countries, to guide and assist them in the area of violence and injury prevention. Much will depend on the funds the VIP department can raise. Dr Krug took this opportunity to officially thank the government of Sweden for paying for this meeting. Given that there are few resources available within WHO for this area of work, collaboration with experts around the world is paramount.

If particular countries would like to get support in tackling violence and injury prevention, the best way is to contact the WHO country office first. However, for a

global project as the one discussed during this meeting, direct contact with headquarters is acceptable.

Participants then discussed in working groups and in a plenary session how WHO could best contribute to national efforts. Suggestions made include the development of several documents as well as advocacy and information sharing.

## **5.2. Guideline on how to develop national policies**

There was consensus that first and foremost WHO should produce a guideline on how to develop national policies on violence and injury prevention. The different issues that should be addressed in such a guideline are:

### ***How to do a situation analysis***

How to make data useful and collect new data as needed

Using data from other countries

Promote/make countries aware about the existing injury surveillance guidelines

### ***The process of developing a national policy on violence and injury prevention***

(see also under 3.2.)

Setting up and leading a consultation to formulate policies

Coordinating organizations

Respect for local initiatives

Developing an alternative process if the political environment is not yet ripe for a policy to move violence and injury prevention forward (opportunistic approach)

### ***Content of a national policy document***

(see under 3.2. for detailed list of contents)

### ***Putting policy into action***

How to translate national policy plan into action

Setting priorities and clear targets

Proposing interventions (lessons learned, practice, research needs)

Evaluation and monitoring

### ***Case studies of experiences from other countries***

Draw on lessons learned to improve policy development and implementation.

## **5.3. Further technical support**

Other technical documents would be very useful in addition to the “generic” guideline. These include:

- More in-depth case studies on how some countries have developed and implemented policies on violence and injury prevention.
- Guidance on how to do a situation analysis including technical guidance on case selection and data analysis, and how to do a political mapping.
- Best practices for violence and injury prevention: there could be several documents for specific topics such as best practices in road safety strategies; best practices to prevent domestic violence etc.

These documents would also be very useful for advocacy purposes and for training.

Beyond producing these documents WHO should play an active role in:

- Stimulating exchange between countries and sharing of experiences on how to develop and implement national policies.

- Promoting debates among different ministries and groups.
- Assisting with national policy formulation and training by providing consultants.
- Convening donors and involving them in the policy formulation process; this includes engaging the World Bank in national efforts to prevent violence and injuries, and providing guidance on how the private sector could participate.
- Providing advice on how to flag violence and injury prevention as a public health problem.
- Connecting violence and injury prevention with the safe community initiative.

Furthermore, WHO should initiate a network of committed persons and organisations willing to promote violence and injury prevention and share experiences. A website with relevant information could be a useful complementary tool.

## **6. Conclusions**

Participants felt that the meeting had been very useful to share different experiences and perspectives from around the world. The timing of the meeting seemed perfect, as there is an emerging willingness in many countries to tackle the issue of unintentional and intentional injuries. Everybody agreed that this meeting should be the beginning of a process to raise awareness on the need for violence and injury prevention and stimulate countries to take action. The meeting was also perceived as an excellent platform to initiate collaboration between WHO and partners in countries. The group constituted for this meeting was asked if they were willing to be active partners of WHO and become members of a network on violence and injury prevention. This invitation was unanimously welcomed.

Dr Krug proposed that WHO draft an outline of a guideline on how to develop national policies on violence and injury prevention. This draft should be reviewed and additional input provided by the members of this group. In June 2004, the 7<sup>th</sup> World Conference on Injury Prevention and Safety Promotion will be an excellent opportunity to emphasize the importance of developing national policies and action plans. A satellite meeting during the conference could be used to present some of the materials developed by WHO and get feedback on a draft guideline on how to develop national policies for violence and injury prevention. It was also suggested that a draft of the guideline could be tested in one or two countries that would like to develop a national policy. Members of the group could assist with this evaluation of the guideline.

## 7. Annexes

### 7.1. Meeting agenda

#### WHO Consultative Meeting “Developing National Policies on Violence and Injury Prevention”

23-24 October 2003- Geneva, Switzerland

#### 23<sup>rd</sup> October 2003: 1. The Process

#### 2. Main components of a policy

- |                      |   |  |
|----------------------|---|--|
| 9:00 – 9:30          | Opening remarks<br>Participant introductions and expectations   | - Dr Etienne Krug,<br>- Dr Doris Schopper                                    |
| 9:30 – 9:45          | Objectives of the meeting   | - Dr Etienne Krug  |
| 9:45 – 10:30         | <b>Plenary presentation.</b> Review of existing national efforts to prevent violence and injuries:<br>- What are the issues?  | - Dr J-D. Lormand,   |
| <b>10:30 – 11:00</b> | <b>Coffee/tea break</b>   |  |
| 11:00 – 12:30        | <b>Plenary presentations.</b><br>What is the process to develop a policy on violence and injury prevention ?<br>- Examples from three countries (Tunisia, Thailand, Vietnam)<br>(15' presentation followed by discussion) | - Dr M. Ben Ammar<br>- Dr Paibul Suriyawongpaisal<br>- Dr Nguyen Thi Hong Tu |
| <b>12:30 – 14:00</b> | <b>Lunch</b>  |  |
| 14:00 – 15:15        | <b>Group work.</b><br>(1) Essential steps in developing a policy on violence and injury prevention<br>(2) Points to be addressed in a policy document on violence and injury prevention                                   | <i>Split in two groups ( each with moderator and rapporteur)</i>             |
| 15:15 – 16:00        | <b>Plenary session.</b> Report-back from the groups and discussion  |  |
| <b>16:00 – 16.30</b> | <b>Coffee/tea break</b>   |  |
| 16:30 – 17:15        | <b>Plenary presentation.</b> Developing policies on child and adolescent health: lessons learned  | - Mr Paul Bloem  |

**24<sup>th</sup> October 2003: 3. How to define a framework for intervention  
4. WHO's contribution**

9:00 – 9:30	Summary of previous day	- <i>Dr R. Waxweiler</i>
9:30 – 9.45	<b>Plenary presentation.</b> WHO's mandate, role and responsibilities	- <i>Dr Etienne Krug</i>
9:45 – 10:15	<b>Plenary presentation.</b> Interventions recommended by WHO to prevent and control violence and road traffic injuries	- <i>Mr Alex Butchart.</i>
<b>10:15 – 10:45</b>	<b>Coffee/tea break</b>	
10:45 – 12:30	<b>Plenary presentations.</b> Developing a framework for intervention: examples from three countries.  <u>Brazil</u> : moving from a broad policy on violence and injury prevention towards a guide for action <u>Germany</u> : the importance of legal interventions to prevent violence. <u>Mongolia</u> : how to implement a national policy <u>Australia</u> : Strategies to prevent injuries and their consequences (15' presentation followed by discussion)	- <i>Dr E. Silveira Rodrigues</i> - <i>Ms Nancy Gage-Linder</i> - <i>Ms Pam Albani</i>
<b>12:30 – 13:30</b>	<b>Lunch</b>	
13:30 – 14:30	<b>Group work.</b> Developing national policies on violence and injury prevention: - What should WHO's contribution be ? - What type of guidelines should WHO produce ? - What should be the content of the Safety Vienna 2004, satellite meeting?	<i>Split in two groups ( each with moderator and rapporteur)</i>
14:30 – 15:15 (with coffee in between)	Report back from the two groups and plenary discussion	
15:15 – 16:00	Next steps	
16:00 – 16:30	Concluding remarks	- <i>Dr Etienne Krug</i>

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