MANY COUNTRIES AROUND THE WORLD still need to put in place effective systems to collect reliable information on violence and injuries in order to understand the magnitude and develop and assess prevention strategies. To assist these countries, WHO has collaborated with a number of agencies to develop guidelines on collecting data. These documents, one on the development of injury surveillance systems and one on conducting community-based surveys, were developed and launched over the last few years, the former in 2001 and the latter in 2004. They are currently being used in a number of countries.

WHO ACTIVITIES

Injury surveillance
Using the WHO Injury surveillance guidelines, a number of countries have translated the document into their local language and have put in place (or are in the process of doing so) emergency room injury surveillance systems. These countries include Bolivia, Cambodia, Colombia, El Salvador, Egypt, Ethiopia, Honduras, Jamaica, Kenya, Libya, Lithuania (see Box 6.1), Mongolia, Mozambique, Nepal, Nicaragua, Oman, Peru, the Russian Federation, Saudi Arabia, The former Yugoslav Republic of Macedonia, the United Republic of Tanzania and Viet Nam. WHO has given technical, and in some cases financial, support to these countries to develop and implement locally appropriate systems. Most of these systems are currently in the evaluation phase, following a short pilot-testing period. Most have already provided important information to the countries concerned, so that policies and programmes for violence and injury prevention can be developed.

In Colombia, the WHO Regional Office for the Americas has given support to so-called “observatories of violence” where officials from health, transport, forensics, the police, and law offices share registries and a unified form of data collection on injury-related deaths. This system is now implemented in 30 cities across the country by the Instituto de Investigación y Desarrollo en Prevención de Violencia y Promoción de la Convivencia Social (CISALVA), a WHO Collaborating Centre for Violence and Health,
with support from the WHO Regional Office for the Americas. With the assistance of
the United States Agency for International Development, the WHO Regional Office
for the Americas and the Inter-American Coalition for the Prevention of Violence aim
to set up similar observatories in selected cities in El Salvador, Guatemala, Honduras,
Nicaragua and Panama.

**Injury surveys**

In 2004, WHO launched guidelines on the process of designing and implementing
a community-based injury survey. The document, entitled *Guidelines for conducting
community surveys on injuries and violence*, provides instructions on how to prepare
for data collection, how to select and train fieldworkers, how to conduct fieldwork
and deal with unexpected situations, how to deal with ethical considerations, as well
as how to enter and analyze data, disseminate the results and use the information for
advocacy purposes. In addition, the guidelines provide:

- a standardized tool for the collection of data, with core and optional components
- a set of model questionnaires
- detailed guidance on how to obtain representative samples
- an explanation on how to calculate sample size.

**BOX 6.1 Lithuania facilitates hospital-based surveillance of violence and injuries**

By Dinesh Sethi, WHO Regional Office for Europe, and Ramune Meiziene, State Public Health Service, Lithuania

Lithuania is a middle-income country with per cap-
ita GDP of US$ 7800. In 1990, the country gained
independence from the former Soviet Union.
Lithuania has since been undergoing rapid socio-
economic transition, characterized by liberalization
of markets and motorization. In common with
some other countries which have undergone transi-
tion, injury rates are high. Injury is the leading
cause of death for people under the age of 65 years.
The standardized mortality rate for all injuries is
148 per 100 000, and the three leading causes are
suicide (42 per 100 000), road traffic injuries (21 per
100 000) and poisoning (20 per 100 000).

Health information systems do not adequately cap-
ture injury information by cause, therefore the
Ministry of Health decided to set up an injury sur-
veillance system in a hospital setting using the
*Injury surveillance guidelines*. The pilot site
chosen was the Vilnius University Emergency Hos-
pital which has over a thousand beds and offers all
trauma care specialties. A steering committee for
the project was established. One of the first tasks
was to translate the guidelines into Lithuanian and
to develop a data collection form. These tools were
pilot-tested, and training sessions on data collection
were held for staff. There are about 100 trauma cases
presenting daily to the emergency department, with
about 10–20 requiring admission. Data collection
is ongoing and it is estimated that data on about
10 000 cases will be collected over a period of about
6 months. To review the project, a feedback work-
shop with stakeholders was held in December 2005,
during which recommendations on how to improve
injury surveillance at national level were made.
Data will be shared with an intersectoral committee
on injury prevention to better develop injury and
violence prevention plans.
Ethiopia, Mozambique, Oman, Saudi Arabia, and Sri Lanka are among the countries using these guidelines.

**Country capacity survey**
WHO is undertaking a survey to provide information on national activities, policy approaches, and basic capacities to prevent violence and injuries. A questionnaire was developed with the assistance of WHO regional office focal persons for violence and injury prevention, and surveys were carried out in countries. Methods of data collection varied according to circumstances. The results will be collated and entered in an online database. The project is a step in the collection of information to support global efforts to prevent violence and injuries. It will assist WHO and global partners in advocating for increased resources, and in identifying examples of successful prevention models. The information gained will put WHO in a better position to support ministries of health in their efforts to implement or improve interventions to prevent violence and injuries. It will also enable WHO to target its advice on underlying policy approaches and partnerships.

**Alcohol and injury multi-country study**
Alcohol involvement in injuries has been demonstrated in numerous studies. Hundreds of thousands of deaths occur each year as a result of alcohol-related injuries, both intentional and unintentional. Alcohol is involved in up to 30% of adult hospital admissions, particularly those to emergency rooms. The problem of alcohol-related injuries is particularly alarming in many developing countries, where alcohol consumption is increasing, injury rates are extremely high, and appropriate public health policies have not been implemented. However, the role of alcohol in injuries is not yet well enough understood and documented to allow for the development of adequate policy responses. The WHO Collaborative Study on Alcohol and Injuries initiated by the WHO Departments of Mental Health and Substance Abuse, and Injuries and Violence Prevention, has been implemented in Argentina, Belarus, Brazil, Canada, China, Czech Republic, India, Mexico, Mozambique, New Zealand, South Africa, and Sweden. Further international efforts in this area will focus on: assessing the causative role of alcohol in injuries presented to emergency rooms, and the associated role of drug use; the role of studies based on data from emergency rooms in developing alcohol policy; and the use of emergency rooms as entry points for interventions targeting harmful drinking and risk of repeated injuries (see Box 6.2).

**Classification systems**
For nearly a decade, under the auspices of WHO, and led by the Dutch Consumer Safety Institute, experts have been working on a classification system that better addresses the specific needs of activities targeting violence and injury prevention and control. The International Classification of External Causes of Injury has now been endorsed as a member of the WHO family of classifications. Version 1.2 of the ICECI classification was released in July 2004 and includes an index. The taxonomy is
currently being translated into French and Spanish. Many countries are using this classification in their injury surveillance systems. For more information, see www.iceci.org.

**Dissemination of data**


**NEXT STEPS**

Over the coming years, WHO will continue to give technical support to countries to help strengthen their capacity for data collection and to further develop, implement and evaluate their information systems. Data on violence and injuries, apart from being essential at local level to develop prevention programmes, can also be fed into global estimates. WHO staff will also contribute to the development of the 11th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD). The chapter of ICD on External Causes of Morbidity and Mortality is of particular concern because in its 10th revision it lacks the scope and specificity needed to address violence and injury prevention effectively. A working group of injury classification experts has been established and they will be given the task of addressing these issues over the coming years. It is expected that the 11th revision of the ICD will start coming into use in about 2010.

**BOX 6.2 Research group proposes priorities for future research on alcohol and injuries**

by Margie Peden, WHO Department of Injuries and Violence Prevention

In October 2005, during an international conference hosted by the Alcohol Research Group in Berkeley, USA, entitled Alcohol and Injury: New Knowledge from Emergency Room Studies, participants identified the following as main areas that warrant more research on alcohol and injuries in the emergency room setting:

- epidemiology of the magnitude of alcohol involvement in injury and involvement by type and cause of injury
- clinical assessment of alcohol intoxication
- methodological comparisons of control subjects for estimating risk of injury in emergency room patients
- methods of obtaining blood alcohol concentration estimates
- brief interventions in the emergency room, including counseling of patients about the harmful use of alcohol
- comparisons of individual-level risk of injury estimates from emergency room studies with aggregate-level data
- implementation of a national alcohol surveillance system
- dissemination of major research findings of recent emergency room studies

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