WHO-EM/HLP/004/E

Summary report on the

Intercountry meeting on developing national injury surveillance systems

Cairo, Egypt
11–13 May 2009

World Health Organization
Regional Office for the Eastern Mediterranean

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1. Introduction

An intercountry meeting on developing national injury surveillance systems was organized by the World Health Organization (WHO) Regional Office for the Eastern Mediterranean in Cairo, Egypt, from 11 to 13 May 2009. The meeting was attended by 18 participants from 16 countries, mostly ministry of health focal points for injury and violence prevention. In addition, representatives from UNICEF, Egypt, and other international experts attended the meeting.

The main objectives of the meeting were to:

- review national data recording and reporting systems and assess how far injuries are recorded and reported in routine health information systems;
- discuss existing best practices of injury surveillance currently favoured in some countries of the Region; and
- agree on a uniform injury surveillance system that could be further adapted according to national contexts.

The meeting was inaugurated by Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, who said that injuries, whether unintentional or intentional, constituted a major public health problem, killing more than 5 million people across the world every year and causing much more disability. Injuries were becoming a major cause of death in developing countries, with increasing urbanization, mechanization, industrialization and globalization. Despite the increasing magnitude of the burden of death and disability due to injuries, prevention had not yet assumed an appropriate position on the public health agenda of most of the Member States of the Region. One important reason, among others, for this was the lack of reliable quality health information on numbers and types of injuries and the circumstances in which they occurred. Such information was necessary to develop effective prevention strategies and to evaluate their implementation.

Data limitations in particular posed a serious challenge. Good public health policy decisions were effectively informed with a sound and robust evidence base. This evidence base was generated through establishing effective information systems which could capture the causality, magnitude and vulnerability of the population to a disease or condition. Routine information systems in the Region were not currently equipped to capture these variables. Instead, data on injuries was collected by hospitals, by police, other law enforcement agencies, insurance companies, transport and a host of other actors. In most cases, these many data systems did not “talk” to each other and did not provide sufficient information to policy-makers for informed decision-making.

Dr Gezairy said that WHO, recognizing the critical nature of the problem, was endeavouring to mobilize governments, organizations and communities to tackle this problem effectively. WHO had been collaborating with different experts to develop the tools needed for collecting data on injuries. One example was the *International Classification for External Causes of Injuries (ICECI)* the first version of which was created in 1998, and was a complement to the International Classification of Diseases (ICD). It provided guidance on how to classify and code data on injuries according to agreed international standards.

Other examples included the *Injury Surveillance Guidelines* and the *Guidelines for conducting community surveys on injuries and violence*, issued in 2001 and 2004, respectively. These guidelines were developed to provide practical advice on how to develop information systems for the collection of systematic data on injuries and conduct a community-based survey to collect information about injuries and violence and resultant disabilities.

Dr Gururaj Gopalakrishna, (India) was elected Chairperson and Dr Salim Said Al Wahaibi, (Oman) as Co-chairperson. Dr Rania Saad (Egypt) was elected as the Rapporteur.

2. Summary of discussions

In order to make participants aware of existing injury surveillance systems, three country case studies (Egypt, Islamic Republic of Iran and Oman) were presented.

In Egypt in 1996 ministerial decree No 156 was issued to establish an injury prevention unit and injury prevention steering committee. In 1999, all governorates were reporting injuries from ministry of health hospitals. Staff training and the maintenance of the surveillance system in terms of reporting forms, equipment and human resources are conducted annually. Some weaknesses of the system include: only 55% coverage of Egyptian reporting facilities; data systems and training require greater standardization, and currently, no national action is being taken for injury prevention. In 2007, the International Classification of Diseases 10 was used as a classifying tool and Training, Educating and Advancing Collaboration in Health on Violence and Injury Prevention (TEACH-VIP) was used as a training tool. Greater collaborative intersectoral efforts are now being exerted. Teaching hospitals were included in the system and by the end of 2009, university hospitals will also be included to raise the coverage rate by 73% of reporting facilities. As a future plan, newly engaged newspaper surveillance will be used as a validation tool. A community-based survey is currently being conducted to determine the national burden of injuries in Egypt.

An injury surveillance system is being developed in Oman. The software is currently being piloted in two governorates following the provision of relevant training to practitioners. Future implementation/scaling up will be greatly informed by this pilot phase.

In the Islamic Republic of Iran, the injury surveillance system project started in 2003 and data gathering was established in 2005. After the introduction of the ‘safe community concept’ in 2003, it was realized

that an effective measure for measuring the impact of safe communities on the reduction of different forms of injury does not exist. This translated into the development of an injury surveillance system which began implementation at local level but which was later expanded to the provincial and national levels.

In the ensuing discussions, focal points from almost all Member States deliberated on existing injury surveillance mechanisms, gaps in current surveillance systems, opportunities that are available but are yet to be exploited and the suggested way forward in terms of seeking assistance from WHO in harmonizing the different injury datasets available with different sectors. It was emphasized by most Member States in the discussion that although the need for harmonizing different data collection mechanisms cannot be over-emphasized, a uniform approach to (a one-size-fits-all) will not be possible due to certain factors, including confidentiality issues, national governance structures and resource availability.

Although the objectives of the meeting were to concentrate solely on injury surveillance, it transpired that many Member States would require an injury prevention plan where an injury surveillance system could be well embedded. In the subsequent group work sessions, a broader spectrum of injury surveillance and its place in national injury prevention plans was thoroughly discussed. Taking advantage of the presence of injury focal points, group work on developing national plans was also conducted. Participants were reminded that plans for injury prevention (where the injury surveillance plans could be embedded) should be reflected in the planning exercise for 2010–2011. WHO tools and guidelines for developing injury surveillance systems were used extensively by participants to enrich their draft plans.

3. Recommendations

To Member States

1. Finalize the proposed countries' plans of action by engaging stakeholders from within ministries of health, as well as other sectors, including UN and non-UN partners at the country level, developing modalities for multisectoral mechanisms and making sure that the Regional Office receives the completed plans by 30 June 2009.
2. Pursue national level studies on the economic burden of injuries (including cost–benefit ratios) and using such data in informing policies and decision-making.
3. Pursue a dialogue with donors and UN agencies at the national level in order to position injury prevention in general, and injury surveillance in particular, in developmental assistance programmes in countries. Look at opportunities where already developmental support is ensured or in the pipeline.
4. Start discussion within your ministry of health and WHO country office for factoring in your plans for injury prevention, including injury surveillance, in the upcoming biennial collaborative planning exercises (Joint Programme Planning and Review Missions) between WHO and the Government.
5. Approach academia/universities/individual researchers at the country level to involve them in your injury prevention efforts, especially in injury surveillance, as they may offer expertise and technical skills which may not be available in ministries.
6. Evolve modalities to include injury data within the routine health information systems and develop a mechanism for coordinating data collection efforts among different sectors by agreeing on a minimum core data set (disaggregated by age, sex and cause) which can regularly be submitted to WHO as in practice for other conditions/illnesses.

7. Arrange training activities to enhance the knowledge and skill base among health care workers from all levels, as well as personnel from other sectors, on how to collect and report injury data.
8. Share experiences with other Member States at the level of the injury focal points, especially those who may have succeeded in securing resources from UN/non-UN agencies.
9. Engage the media on a continual basis in their efforts for injury prevention particularly using the influence of the media in putting injury prevention high on political agendas. The inclusion of the private sector in injury prevention efforts also needs to be explored strategically.
10. Embark upon a comprehensive injury prevention and control strategy, including a clear framework for disability and rehabilitation.

To WHO

11. Provide the necessary technical expertise, normative guidelines and protocols to Member States for injury prevention in general, and injury surveillance in particular.
12. Support Member States in arranging training and capacity-building activities for enhancing the knowledge and skill base about injury prevention and injury surveillance among ministry of health staff, as well as staff coming from other relevant sectors.
13. Engage other UN partners in providing support for Member States on either all of the injury disciplines or specific disciplines, for example child injury prevention.
14. Ensure continuous follow-up with ministry of health counterparts, not only on the finalization of the proposed action plans but in assisting Member States on operationalizing these plans.
15. Assist Member States in evolving multisectoral mechanisms for injury prevention, as well as in integration of injury surveillance data among different partners at the national level; and propose to

the national teams and WHO Representatives to include injury prevention in general, and injury surveillance in particular ,in the forthcoming biennial planning exercises.