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Global Medium-Term Programme

Programme 8.3

ACCIDENT PREVENTION

Despite the evident overall significance of accidents for public health, the number of countries that have established adequate policies and programmes based on sound scientific evidence and available safety technologies, is still too low. The situation is particularly imbalanced and detrimental to developing countries, where deaths from injuries rank now among the first five causes of general mortality, and where the protection of consumers and communities against hazards is often a reflection of a compromise between safety needs and economic pressures. The powerful role of underdevelopment in determining the extent of the injury problem and potential for action in developing countries should be constantly emphasized.

In support of national policy formulation, WHO has contributed during the Seventh General Programme of Work (7th GPW) to improving information on accidents, especially in developing countries, and by the end of this period it was possible to draw some conclusions on the basis of the information collected and analysed, particularly concerning differences between developed and developing countries and specific requirements for the latter.

On the basis of those achievements during the 7th GPW, the trend of the programme for the Eighth General Programme of Work (8th GPW) will be to shift emphasis from the basic data and knowledge acquisition phase to a more operational one aimed at better elucidating cultural and socioeconomic determinants of injury causation, creating greater political and public awareness of health damage caused by injuries and integrating a safety or injury prevention component into health promotion and protection policies. The main thrust of the programme will be on developing policy principles and supporting action programmes that are community-oriented, particularly at district or more local level.

CONTENTS

1. Introduction and policy basis

The activities and approaches of the accident prevention programme aim at providing countries and regions with the necessary support to develop related national or regional preventive strategies within their overall efforts to implement the Global Strategy for Health for All by the year 2000.

Activities will concentrate on the development of epidemiological knowledge and preventive tools, which will stimulate and support the development of national accident control policies and programmes. In particular, efforts will be directed towards developing and adapting technology so as to eliminate accident hazards at all levels of individual or community activities, as part of the strategy for general health protection and promotion.

The first resolution requesting WHO to play an active role in accident prevention and coordination of related research was adopted by Member States in 1966 (WHA19.36). A further resolution emphasizing international action to be taken in the field of traffic safety was passed in 1974 (WHA27.59); in 1976 both the Executive Board and the World Health Assembly reviewed the programme, and the Executive Board adopted a resolution requesting the development of a formal programme (EB57.R30). In addition, the Member States in two regions adopted resolutions regarding the development of regional programmes relevant to the special requirements of each region (EUR/RC26/R2) and (WPR/RC28/SR/6).

2. Situation analysis

The principal causes of injuries are those associated with the occurrence of motor vehicle accidents, falls, drownings, burns and poisonings or with various types of violent behaviour. In this respect, injuries can be intentionally or unintentionally produced. Depending where they occur, accidents are usually classified as traffic, home or domestic, school, sport and leisure, or occupational accidents or injuries. For the sake of avoiding confusion in terminology, accidents (an event when various factors interact to eventually produce an injury) must be differentiated from injury, which is the health outcome. Intervention can take place before the accident occurs, (primary safety measures) or after the accident to prevent injury occuring or mitigate it (secondary safety measures).

Injury, intentional or not, is one of the principal public health issues, with individual, social and economic consequences that still remain largely underestimated by governments and the public. Crude figures show 2 670 000 deaths reported yearly worldwide from injury and poisonings,[1] about 2 million of which occur in developing countries. Some 120 000 people die on the roads each year in countries of the OECD, 50 000 in the EEC alone. In Sweden about two deaths occur per 10 000 motor vehicles on the road, whereas in Kenya this figure is about 60. By the beginning of the 1980s, about 44% of all deaths of boys aged 5-14 years were due to accidents in Sweden as compared with 8% in Egypt, but the death rate per 100 000 inhabitants for this age group was higher in Egypt than in Sweden: 14.7 and 13 respectively.

It is clear that, for health planners, the absolute number of accidental deaths or their crude rate is not sufficient to assess the magnitude of the accident problem. Accidental deaths as a percentage of all deaths and their ranking among leading causes of mortality has to be considered when establishing priorities. In an analysis of the ranking of accidents among the leading causes of death made by WHO,[2] accidents were included in the five leading causes of death in all but a very few countries. Using the potential years of life lost as an indicator further emphasizes the importance of this cause of death and underlines its major socioeconomic consequences, since children, adolescents and young adults pay a particularly heavy toll in accident mortality. For

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[1] World health statistics annual, World Health Organization, 1984, Geneva.

[2] World health statistics quarterly, 39(3): 255 (1986).

instance, in 1981, the potential years of life lost due to accidents to young people as a percentage of that for people aged 1-65 years lay between 49% in Sweden and 78% in Egypt. This percentage is generally highest in developing countries. During the period 1977-1981, accidents were the leading cause of death for people aged 1-24 years in more than half of nearly 60 developed and developing countries for which information was available. They are even now the leading cause of death between the ages of 1 and 40 years in an increased number of countries. Injury is also the primary cause of the loss of more working years of life than all forms of cancer and heart disease combined. Only AIDS is now beginning to compete with accident and violence as a cause of death in these age groups.

However, in countries with constant or slightly decreasing patterns, changes in mortality are no longer sufficient to represent the situation or even to evaluate the effectiveness of countermeasures. Other indices have to be used based on morbidity data. As part of morbidity data, better documentation on permanent disabilities resulting from accidental injuries is also strongly needed. Unfortunately, for the time being very few health systems appear to be able to calculate the impact of accidents on the overall morbidity or disability figures in a given community. The relationship between mortality and morbidity is often not at all clear, and the decline in mortality observed in some countries may well be counterbalanced by an increase in severity of injuries and morbidity, especially in long-lasting or permanent disabilities.

During the 7th GPW, constant attention was given by WHO to the need to document morbidity and disability from injuries, and to establish methodological tools for this purpose.

For example, in the United States of America, motor vehicle accidents cause about 50 000 deaths each year but 2 million disabling injuries; and while approximately 6000 deaths result from burns, 60 000 people injured by burns are admitted to hospital. Apart from the total of 140 000 deaths by injuries in the United States, an additional 80 000 will be affected by permanently disabling injuries of the brain or spinal cord and 2000 will remain in a constant vegetative state. In India, where a large underreporting exists, about 10 000 deaths are attributed to burns each year, and there are about 1 million disabling burn injuries.

In both developed and developing countries, 10-30% of all hospital admissions are the result of accidents. Such admissions are costly because of the demands they make on emergency, diagnostic and therapeutic care, often involving highly sophisticated technology and the additional need for long-term rehabilitation. The situation is worse in many developing countries where an inadequate infrastructure for the management of injuries leads not only to increased mortality but also, and more significantly, to an increased number of severe disabilities. For instance, in India, case fatality rates for burns can be very high (30-40%) in some locations, due mainly to infections.

In the United States, injury represents the first cause of primary contact with physicians. About 150 million hospital bed days are necessary to treat injuries, and one out of every eight hospital beds is occupied by injury patients. In the EEC, about 30-33 million injuries that occur at home or during leisure-time activities are treated medically each year. In Thailand, the primary cause of mortality and morbidity is related to violent incidents, namely homicides and traffic accidents. A trivial accident such as a fall represents a major cause of injury, especially in childhood and aging (as per the WHO analysis on this subject). In the elderly, for instance, a fall can frighten someone to the extent that it will limit his or her social activities, frequently leading to a deterioration in that person's health. It should be emphasized that physical and psychological distress and disabilities, which often result in severe handicaps, may be caused by severe injuries or even mild ones. Brain injuries often result in long-term disabilities, as do spinal-cord injuries and, in many circumstances, they can cause considerable disruption in families. There is a need to assess more fully the psychological impact of an accident or injury on not only the subject but also the family or nucleus of close relatives, since the handicaps that result from these situations are likely to be much more severe than generally thought. Children and adolescents constitute

a high-risk group owing to their vulnerability at various stages of development, and in all countries young children, women and the elderly are particularly exposed to the risk of domestic accidents. Several WHO activities have taken place, and documentation on the problem of accidents or violence within these groups has been initiated.

Motor vehicles are a leading cause of minor-to-serious injuries and the main cause of the severest injuries. About half of all acute brain or spinal-cord injuries from external causes are sustained in motor vehicle crashes. The economic burden can be excessive, even for highly developed countries, where the related social costs of motor vehicle injuries are exceeded only by those of cancer and cardiovascular diseases. While no price can be set on death and disability, the economic burden to society of deaths and disabilities owing to accidents can be measured in terms of both the loss of productivity and the extent and cost of the use made of medical and rehabilitative services. Economic costs due to injuries can be staggering. In the United States in 1986 health costs from injuries ranked second (US$ 82 000 million) after heart diseases (US$ 85 000 million) and before cancer (US$ 50 000 million) and infectious diseases (US$ 10 000 million). In the same country, more years of working life were lost from injury each year (about 4 million years of working life) than from all forms of heart disease (2.1 million years) and cancer (1.7 million years) combined. In the EEC, traffic trauma amounted to about ECU 40 000 million in 1985.

With regard to research into accidents, the slender resources allocated do not reflect their high cost to society. For instance, in the United States, resources for cancer research are about ten times greater than those devoted to accident research, although the number of years of life lost due to cancer is approximately half of that due to accidents. With regard to research priorities, it has been estimated that the marginal cost of environmental modifications to improve road safety is now too high in relation to the benefits they could bring in developed countries. Thus, there has been a shift of policy towards education and research into the social or behavioural determinants of road safety. Although this approach has not yet been confirmed, with regard to many developing countries where environmental parameters may rank high in injury causation, an appropriate level of priority should nonetheless be given to interventions and research aimed at increasing knowledge of factors in the social behavioural field that relate to injury causation, as a complementary support to environmental interventions. These problems were reviewed by several technical groups and the ACHR during its session in 1988.

In developed countries, policies and programmes on motor vehicle injuries can be based on quite satisfactory data bases, but this is not the case for domestic injuries. In most of the developing countries, information on all types of accident is either scarce or nonexistent and lacks reliability. The quality of basic epidemiological data must therefore be improved, particularly through the design of simple, practical and low-cost information and monitoring systems. Despite the evident overall significance of accidents for individual and public health, few countries have yet established adequate policies and programmes and made appropriate resource allocations. In terms of action, politicians and decision-makers in health and other relevant sectors such as education, justice, transport, housing and social welfare must be made aware of the catastrophic consequences of injuries in communities and must realize that many of them are preventable. For instance, the argument often used that marginal cost for safety hampers its promotion cannot stand in front of obvious returns in health and economic terms that could be provided by, for instance, installing seat belts and fitting laminated windscreens in cars, using special flame-retardant material in housing and clothes and using special types of child-proof container for toxics.

During 1984-1989 WHO was instrumental in ensuring the contribution of the health sector to an intersectoral approach for safety promotion in communities. Policy analysis, technology assessment and information exchange in support of the formulation of national road safety programmes were undertaken in all regions in line with policy principles formulated during the first WHO Conference on Road Accident Prevention in Developing Countries held in Mexico in 1981. Multisectoral boards were established in several countries. In the Caribbean, the Conference of Health Ministers adopted WHO proposals for establishing accident prevention programmes coordinated by the Caribbean Epidemiology

Centre (CAREC) in Trinidad. Close cooperation was established with the departments of transportation of the World Bank, and a road safety component is now included in loans provided by the Bank for transport development projects, the UN Regional Economic Commission, particularly UN/ESCAP, UN/ECE and UN/ECA. WHO also advocated the inclusion of accident prevention in HFA strategies and national health plans in several countries in all regions, and has undertaken specific supportive actions on this basis. A comprehensive collection of data and information on domestic accidents was initiated in all regions, and specific coordinated projects on childhood accidents and accidents in aging (particularly on falls, burn injuries and poisonings) were carried out in several countries and led to the inclusion of several national accident programmes in HFA strategies and national health plans.

Transition between the 7th GPW and the 8th GPW and future trends

During the 7th GPW, WHO focused its activities on basic data and knowledge acquisition and building up an intersectoral and public health concept of accident injury analysis. Through this process, the necessity to consider safety as part of the health promotion concept came naturally as well as the necessity to formulate strategies to get the message across that safety is one of the concerns of communities and individuals, so that they become advocates of their own safety and the main partners in finding solutions for the promotion of community safety. This will mean acknowledging the role that local organizations and NGOs active in health and related sectors can play. It will also mean securing the cooperation of various sectors of industry and making them aware of the need to meet safety standards for domestic products, particularly in countries where no specific legislation for consumer safety exists, and to secure full support at central governmental level.

Three WHO activities took place at the end of the 7th GPW to initiate this process, namely a symposium on accident and injury prevention at primary health care level in Thailand, the preparation of a policy document on community safety promotion, and a study group on new approaches to improve safety, in Geneva. WHO packages, including the main elements for programme management of community injury control programmes based on experience acquired by WHO during the 7th GPW and for national district and local community use, were prepared. They will help in establishing demonstration programmes on safety promotion in communities during the 8th GPW, called the "SAFECOM" network, linked possibly to relevant WHO projects such as the Healthy Cities project in the European Region, and supportive of national safety programmes and policies.

The main thrust of the programme will be on developing policy principles and supporting action programmes that are community-oriented, particularly at district or more local level. In line with the philosophy of primary health care, specific account will be taken of local situations and the need for locally adapted safety strategies and technologies that communities can afford. Particularly the powerful role of economic poverty or underdevelopment in connection with safety (because it costs a few pennies more, many families will use the product that costs a few pennies less but is often the most harmful) makes for a definite relationship between safety improvement and meaningful economic development, which will support the trends in countries to decentralize responsibility at the local level or safety efforts, but will ensure backing as appropriate at central level. It will take into account the extreme diversity of situations, particularly between developed and developing countries, which prevents finding standard solutions, calls for strategies based on each country's circumstances and not for grafted unchanged solutions from the developed world in particular.

3. Objective

3.1 General objective The objective is to contribute to health through the prevention of accidents (see objective 8 of the 8th GPW).

3.2 Specific objective To cooperate with countries for road and domestic accident and injury health impact assessment, promoting appropriate safety technologies and formulating relevant policies and programmes for safety, based on community safety programme development.

4. Targets

By 1995:

(1) 60% of countries will have assessed the magnitude and determinants of domestic and traffic accidents in their populations on the basis of epidemiological studies;

(2) 50% of countries will have developed policies and programmes, incorporating intersectoral action, for the prevention of domestic and traffic accidents, and the mitigation of their consequences.

5. Approaches

At country level, WHO will cooperate with ministries of health and other ministries concerned to increase awareness of the consequences of accidents for health and for the health services, and the potential for their prevention. It will support countries in creating intersectoral mechanisms, and in policy and programme formulation, including related legislation. To this end, WHO will provide relevant technical expertise and information that will cover, inter alia, successful country experiences. It will support countries in formulating guidelines on the inclusion of domestic safety programmes in national community health programmes and on the role of the health sector in road accident prevention.

As accidents are often closely associated with community lifestyles, major efforts will be made to support action-oriented community programmes and encourage community action through information and education of the public. Seminars with nongovernmental organizations, consumer associations and industry will be supported, particularly in the field of domestic accidents. WHO will also support training activities for health personnel on accident prevention.

At regional level, WHO will ensure coordination with relevant regional intergovernmental and nongovernmental organizations, to ensure a health input to safety measures. Intersectoral cooperation and exchange of experience will be facilitated. This will involve decision-makers in the fields of transport and health and accident prevention experts.

In research and training, WHO will work closely with selected national institutions to promote exchange of expertise, produce training materials adapted to local needs and cultures, promote research interest and skills in injury prevention, and facilitate technical cooperation among countries.

At global level, WHO will disseminate information on the methodology of epidemiological studies on accidents, as well as criteria for monitoring and evaluating accident prevention programmes. The Organization will continue to collect, analyse and assess country experiences and policies, particularly with regard to programme management and production of appropriate technology. WHO will make such information available in support of national programmes. It will create awareness of the cost-benefits of accident prevention.

WHO will endeavour to promote a dialogue with both industry and consumer groups for the promotion of product safety. It will also strengthen coordination with nongovernmental organizations for programme implementation in Member States. In the field of accident prevention, it will collaborate with appropriate United Nations agencies and nongovernmental organizations such as the International Organization for Standardization.

The programme will also collaborate with other relevant WHO programmes working in this field in promoting a safe environment and healthy lifestyles. It will pool international expertise in the field of domestic and road safety to support national programmes, and will closely cooperate with nongovernmental organizations and the media in sensitizing public opinion and providing the general public with relevant information.

6. Activities

6.1 Assessment of accident and injury impact on health, technology for prevention and research.

TARGET (1): By 1995 60% of countries will have assessed the magnitude and determinants of domestic and traffic accidents in their populations on the basis of epidemiological studies.

Sub-target 1: By 1993 at least 30% of the countries where accidents and injuries constitute a public health problem will have made detailed analyses of the main socioeconomic and environmental factors linked with accidents and injury occurrence in communities.

Activities	1990-1991	1992-1993	1994-1995	Linkages[1]
Accident and injury assessment				
1. Support to baseline assessments of socioeconomic and environmental determinants of accidents and injury occurrence for planning of intervention.	Selected countries in All Regions			CCs NGOs HST
2. To initiate and support specific studies on health cost of major types of injuries and potential economic savings brought by available preventive technologies.	HQ EURO, AMRO, WPRO			CCs NGOs World Bank OECD
3. To strengthen the network of national collaborating centres at regional and global level for information analysis and dissemination services. On this basis establish a global data bank and documentation on accident and injury "SAFENET" and market success stories of safety interventions.	HQ All Regions			CCs HST ORH
4. Each biennium, publish and update previous analysis of accident - injury data from the WHO data bank with special regard to accident in adolescence, aging and severe traumatic injuries, like head, spinal cord and burn injuries.		HQ		HST* ADH* HEE*

Sub-target 2: By 1995, WHO in cooperation with Member States will have produced basic assessment of technologies for injury prevention or community safety promotion.

Activities	1990-1991	1992-1993	1994-1995	Linkages[1]
Technology for prevention, research				
1. Expert committee on technologies for safety promotion and injury prevention.	HQ			CCs
2. To organize each biennium in cooperation with one or more collaborating centres a scientific meeting and produce a technical monograph or report on the following issues:				
- health and safety in the community			HQ/SEARO	CCs
- environmental aspect of injury risks and prevention			HQ/EMRO EURO	OCH* CCs RUD*
- epidemiology and prevention of burns, poisonings, drownings, falls and other domestic injuries			HQ/AFRO	ICS* HEE* MCH*
- accident and injury in childhood and adolescence		HQ/AMRO		ADH*
- psychosocial and environmental issues related to safety in the aged		HQ/EURO		MNH PEH HEE*
- Assessment of alcohol, drugs and other toxics in injury causation and strategies for prevention		HQ/WPRO		MNH*
- Sports and leisure accidents.	EURO			
- Role of women in safety promotion	HQ/SEARO AFRO, WPRO			FHE/MCH*
3. Assessment of existing legislation and analysis of legislative needs in support of community safety programmes	All Regions			NGOs CCs HLE*
4. Establish and maintain an inventory of institutions, individuals, research and control programmes, intersectoral bodies active in the injury field and produce an updated offset document every two years.	HQ All Regions			CCs NGOs

[1] Jointly planned activities are marked with an asterisk.

Activities	1990-1991	1992-1993	1994-1995	Linkages[1]
Advisory bodies, external support				
5. To convene each biennium an Advisory Committee on Accident injury prevention, followed by a meeting of heads of collaborating centres with regional focal points for information exchange, coordination and technical cooperation.	WPRO	SEARO	EMRO	CCs KPD
6. Identification and mobilization of possible external resources for supporting national programmes.	HQ, AFRO, SEARO, EMRO, AMRO, WPRO			NGOs CCs COR* UNDP

6.2 National programme development

Activities under this heading are the direct continuation of those developed during the 7th GPW as support to policy and programme development which produced, especially through pilot exercises, basic instruments like standard protocols for programme monitoring, educational material or basic information for programme planning and evaluation. The shift of emphasis is now on comprehensive community safety programme development under one main target and two sub-targets.

TARGET (2): By 1995 50% of countries will have developed policies and programmes, incorporating intersectoral action, for the prevention of domestic and traffic accidents, and the mitigation of their consequences.

Sub-target 1: By 1995, 50% of the countries where accidents and injuries constitute a public health problem will have established an operational intersectoral infrastructure for the management of safety programmes, community based, with active and appropriate health sector input within the health promotion movement.

Activities	1990-1991	1992-1993	1994-1995	Linkages[1]
Strengthening of national capacities				
1. Elaboration of consensus guidelines on injury surveillance systems at both hospital and community level.	HQ EURO/AMRO			HST, ORH* ISS, ICS* OCH*
2. Development of software and hardware system to support data collection and analysis of injuries in countries and methods to display injury trends in time and place.	HQ EURO/AMRO			CCs EEC* OECD
3. Develop prototype injury surveillance systems to test their effectiveness in monitoring mortality and especially morbidity trends, identify outbreaks and provide a basis for formulating control programmes.		HQ EURO, AMRO, WPRO, EMRO		UN/ECE* ESCAP*
4. Promote specific training in national injury assessment on the basis of methodological tools produced during the previous GPW.		HQ All Regions		
Advocacy and intersectoral coordination				
5. Maintain liaison with IGOs, multilateral and bilateral agencies to provide updated information on the magnitude of injury, be instrumental in developing an intersectoral understanding and approach to prevention and control and in allocating an appropriate level of resources for national programme support.		HQ		COR IGOs
6. Convene once every two years the WHO/NGO injury forum to support country programme development, disseminate relevant information, advocate safety and support educational campaigns.		HQ		COR NGOs*
7. To convene periodically a WHO/media meeting and produce appropriate audio visuos to support the WHO advocacy role in relevant safety issues.		HQ, All Regions		IDH*

[1] Jointly planned activities are marked with an asterisk.

Sub-target 2: By 1993, WHO in cooperation with Member States will have supported the development in at least 30% of the countries where injuries are of public health concern, of demonstration, community injury prevention programmes at district level, fully integrated with health promotion and protection activities.

Activities	1990-1991	1992-1993	1994-1995	Linkages[1]
Support to national programme development through demonstration programmes on safety promotion in communities "SAFECOM network"				
1. Elaboration of criteria for the management of community safety programmes at district level and production of reference learning/teaching material.	HQ, Selected Countries SEARO/AFRO/AMRO			NGOs
2. To cooperate with Ministries of Health in establishing intersectoral national and subnational committees for technical advice, mobilization of resources, support to demonstration programmes and subsequently policy formulation for national safety programmes.	Selected Countries in All Regions			CCs NGOs UNDP World Bank
3. In each country where a demonstration programme takes place, support training courses and production of material for health personnel in injury prevention and safety promotion and management with emphasis on community safety management.	Selected Countries in All Regions			CCs ORH*, MCH ADH
4. To promote the establishment of national NGO collaborative groups and support advocacy groups for programme development in specific areas like burns, poisoning, accidents in the aged, child/adolescent injuries especially head injuries and spinal cord injuries, traffic injuries, domestic injuries.	Selected Countries in All Regions			NGOs
5. To convene once every two years a "SAFECOM" evaluation meeting and market success stories and disseminate results through newsletters and offset documents.	AFRO, SEARO, WPRO			CCs NGOs

[1] Jointly planned activities are marked with an asterisk.

7. Programme management and resources

The management of the programme will retain the same structure as for the 7th GPW, whereby it will be delivered to Member States in close cooperation with regional offices, particularly through joint headquarters/regional integrated projects so as to ensure the best use of the limited available resources in support of country programmes. It will also ensure the relevance and adequacy of global activities to regional and country needs.

The regular budget allocated will only be the catalyst to initiate the activities envisaged during the period, and substantial amounts of extrabudgetary funding support will be required to achieve the targets, especially at country level. The promotion of fund-raising, primarily for country activities, is a fundamental task of the Organization in the years to come. It will have to be considered taking into account the potential contribution of the various sectors involved, and a joint programming with international or bilateral agencies will probably be needed in many respects for this purpose.

Since the start of the 7th GPW, there has been rapid development of working links with several national institutions, some of which have been designated as WHO collaborating centres: five in Europe (France, Netherlands, Sweden and the United Kingdom) one in the United States of America, three in the Western Pacific (Australia and Japan), two in South-East Asia (India and Thailand).

Achievements in countries through cooperation with NGOs such as the International Paediatric Association (IPA), the Association of Latin-American Paediatric Societies (ALAPE), the International Society for Burn Injuries (ISBI), the International Society for Social Gerontology (ISSG), the International Medical Society of Paraplegia (IMSP), the International Road Safety Organisation (PRI) and a few national societies demonstrated the usefulness of partnership in programme delivery in countries, and a forum will meet each biennium to reinforce and expand cooperation successfully developed during the 7th GPW with this network of organizations.

8. Monitoring, evaluation and indicators

An overall evaluation of the programme during 1984-1989 will take place in 1989 with the presentation of a DG's Report to the Forty-second WHA and this information will serve as baseline for another such evaluation at the end of the 8th GPW.

Evaluation of managerial efficiency, and to the greatest extent possible of programme impact in countries, is an integral part of the monitoring of activities listed in chapter 6.

At the beginning of each biennium, and jointly with a programme advisory committee, an inbuilt evaluation component for each activity is formulated in the form of output indicators for the sake of assessment at the end of the biennium and in conjunction with the biennial programme budget cycle. In view of their close involvement in programme delivery, the group of collaborating centres for the programme will be associated with this review/evaluation exercise and will at the same time assess the impact of their contribution on the basis of the established plan of work.

Therefore, progress will be monitored through specific output indicators for each activity, such as the number of countries that have established intersectoral committees, the number of countries with legislation oriented towards central support to community safety intervention, the number of countries where ministries of health have included injury prevention in national health programmes and allocated specific resources, the number of demonstration programmes developed in community safety and the extent of their integration in primary health care activities, the number of districts or areas involved and the population covered.

Programme impact, expressed according to the traditional indicators as trends in mortality, morbidity, disability rates, percentage of hospital beds occupied by the injured, percentage of injured treated in primary health care centres, etc., is a more complex and long-term exercise and should take into account the specificity of indicators used in the sense that, generally speaking, it is not possible to relate variation of

indicators to one cause or intervention. Yet it is, in fact, at country level that, for each activity, quantification of target and specific indicators or output will allow assessment of programme delivery in terms of effectiveness and relevance. Such evaluation should be made possible in the frame of the development of demonstration programmes listed in chapter 6, which will systematically include built-in monitoring and evaluation indicators.

In addition, an asssessment of the extent to which various WHO recommendations are considered and applied at international and national levels will be made. Evaluation of activities will also take into account indicators used by other agencies, when intersectoral types of projects will take place, for instance, in areas such as transport, housing, consumer product safety and related legislation.

9. Linkages

In view of the focus of the programme (support to broadly based intervention programmes), linkages are essential and are viewed from the following perspectives.

- Interdisciplinary needs. The tables in chapter 6 list other technical programmes in WHO which either can provide important technical input or have an advocacy role.

- Intersectoral needs. The main IGOs have been listed in chapter 6 on the basis of already initiated cooperation during the 7th GPW and with which cooperation and coordination are needed for delivering broadly based environmental-health-oriented programmes in Member States. The list should expand during the 8th GPW. Intersectorality will also be promoted through the SAFECOM network mentioned above, which will offer a unique opportunity to match the decentralized policies of various sectors to community safety enhancement.

- Programme implemention at district level. Apart from the role played by IGOs, the role of NGOs will be fundamental and the WHO/NGOs forum planned in chapter 6 will aim at undertaking joint efforts on the basis of respective programme priorities at country level. Links with, for example, women's and professional associations, e.g. architects, in relation to home architectural design for safe domestic settlements for children and the aged or with groups of advertisers and consumers with regard to advertisement practices in relation to product safety will be established.

- Technical cooperation. The network of collaborating centres or institutions working with WHO on other types of agreements, such as memoranda of understanding, will be considered as true partners in the planning, delivery and evaluation phases of the programme. They should be instrumental in three main fields: provision of knowledge to WHO and countries, advocacy, and location of potential external financial resources. Each biennium, a meeting of the heads of these centres will take place, particularly in conjunction with the preparation of the biennial budget.

Annex

List of Abbreviations

WHO Reference Symbols

ADH	Adolescent Health
APR	Accident Prevention Programme
CC	Collaborating Centre(s)
COR	External Coordination for Health and Social Development
FHE	Family Health
HEE	Health of the Elderly
HST	Health Situation and Trend Assessment
ICS	International Programme on Chemical Safety
IEH	Public Information and Education for Health
ISS	Informatics Management
MCH	Maternal and Child Health
MNH	Protection and Promotion of Mental Health
NGO	Nongovernmental Organization(s)
OCH	Workers' Health
ORH	Oral Health
PEH	Promotion of Environmental Health
RPD	Research Promotion and Development, including research on health-promoting behaviour
RUD	Environmental Health in Rural and Urban Development and Housing
WHA	World Health Assembly
WHO	World Health Organization

Others

EEC	European Economic Community
ESCAP	Economic and Social Commission for Asia and the Pacific
OECD	Organisation for Economic Cooperation and Development
UNDP	United Nations Development Programme
UN/ECE	United Nations Economic Commission for Europe

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