



**REGIONAL COMMITTEE FOR AFRICA**

**AFR/RC53/10 Rev.1**

19 June 2003

Fifty-third session

Johannesburg, South Africa, 1–5 September 2003

**ORIGINAL: ENGLISH**

Provisional agenda item 8.3

**INJURY PREVENTION AND CONTROL IN THE AFRICAN REGION:  
CURRENT SITUATION AND AGENDA FOR ACTION**

**Report of the Regional Director**

**EXECUTIVE SUMMARY**

1. Until recently, unintentional and intentional injuries did not receive the visibility they deserved as major health problems. This lack of attention was mainly due to a lack of well researched information and public awareness regarding the magnitude of the problem as well as a shortage of reliable and systematically collected data. Deaths due to injuries and violence are often under-reported or not reported at all.
2. Injuries are social problems with major public health implications in both developed and developing countries. Injuries represent 11% of the global mortality rate and 13% of all disability-adjusted life years lost. In the year 2000, in the African Region alone, an estimated 725,000 people died as a result of injuries, accounting for 7% of all deaths in Africa and 15% of worldwide injury-related deaths.
3. The health, economic and social impacts of injury and violence are more significant in poor countries and for disadvantaged populations. Injuries may lead to poverty, and poverty is a risk factor for injury and violence. In the African Region, road traffic accidents, conflicts and interpersonal violence are the leading causes of mortality and disability related to injuries.
4. The health sector is the final common denominator of all injuries. Information, education, communication, surveillance of data, pre-hospital care (including emergency and ambulance services), hospital care and rehabilitation involve the individuals and institutions of the health care sector.
5. Therefore, the health sector is central to raising awareness, mobilizing other sectors and stakeholders, advocating for and contributing to the formulation, adoption and implementation of comprehensive, evidence-based policies, strategies and programmes to prevent and manage injuries and violence as well as their consequences.
6. The Regional Committee is invited to consider this document and endorse the proposed agenda for action.

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## INTRODUCTION

1. In the year 2000 there were approximately five million deaths worldwide due to injuries. In addition to the people who die each year, millions more are temporarily or permanently disabled as a result of nonfatal injuries.
2. Injuries and violence received international attention in a World Health Assembly resolution of 1996.<sup>1</sup> This resolution recognized the increasing importance of violence as a leading worldwide public health problem and urged Member States to assess the problem within their own territory and requested the Director-General to initiate relevant public health activities.
3. Like diseases, injuries result from the interaction (crash, shooting, burning) of an agent (mechanical, thermal energy, natural disaster) host (human) and vector (motorcycle, fire, weapon). Based on this definition, injuries can no longer be regarded as “accidents” resulting from random events but rather as predictable outcomes from actions within a risky environment. Therefore, injury prevention and control involve the same principles as any other public health problem.
4. Injuries are categorized as unintentional and intentional. Unintentional injuries are the result of road traffic crashes, poisoning, falls, fires, drowning and natural disasters; intentional injuries may be from interpersonal, collective<sup>2</sup> and self-directed violence.
5. Until recently, injury and violence did not receive significant attention as important health problems. This lack of recognition was mainly due to lack of awareness regarding the magnitude of the problem, compounded by a shortage of reliable and systematically collected data.
6. There are environmental and behavioural factors that underlie specific categories of injuries and violence. These can be grouped into factors at the individual, community and societal levels. Prevention involves reducing these risk factors and can significantly reduce the societal burden of injuries.
7. Injuries and violence have more harmful effects on poor countries and disadvantaged populations. Fatality rates from different types of injury are higher in developing countries. Violence often originates from and is compounded by poverty and social exclusion. On the other hand, injuries and violence and their consequences may lead to poverty at individual, family and community levels. Thus, injury and violence prevention should be placed in the context of long-term poverty reduction strategies.
8. Injuries are costly. Emergency department treatment, hospitalization and long-term care often divert scarce resources from other development priorities. Injuries may cause lifelong disabilities and result in other health problems that may have serious consequences for individuals, families, communities and health care systems. Investment by Member countries

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<sup>1</sup> Resolution WHA49.25, Prevention of violence: a public health priority, 1996.

<sup>2</sup> Collective violence is by a group against another group or set of individuals and takes the form of genocide, repression, human rights abuses, terrorism or organized violent crime. WHO, *World report on violence and health*, Geneva 2002.

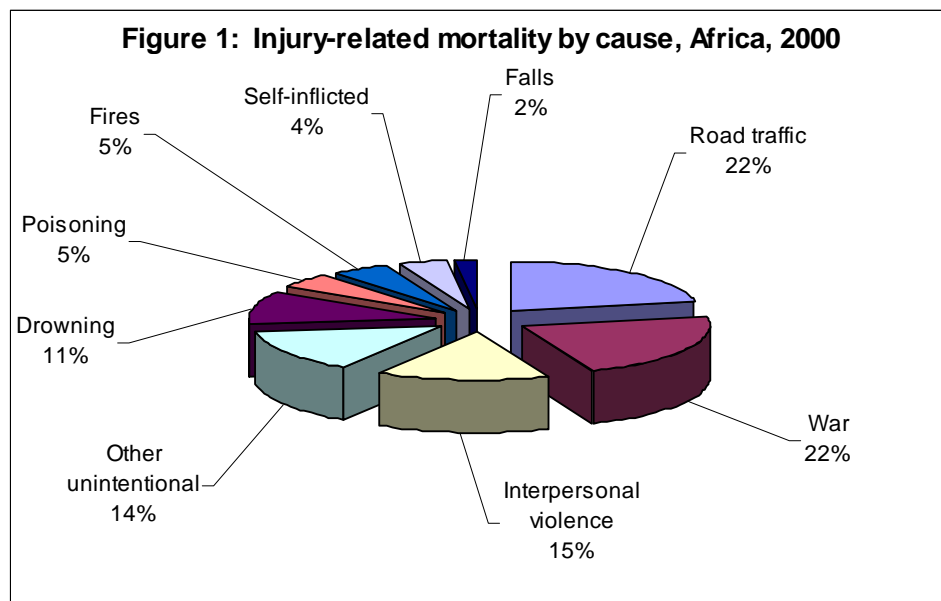
in comprehensive injury and violence prevention and control programmes<sup>3</sup> as well as emergency mechanisms will therefore have enormous economic and social benefits.

9. This document gives an overview of the current situation with regard to injury and violence in the African Region, and their overall impact on economic and social development. It proposes an agenda for action to address the worsening situation.

## CURRENT SITUATION

10. While injuries have major societal and economic consequences, data regarding injuries and their aggregated impact are rarely systematically collected and may be spread across many institutions and organizations. Thus, globally, and more so in Africa, there are serious gaps in the data relating to injuries.

11. There are regional differences in the profile of injury and violence depending on the prevailing economic, political, sociocultural and historical factors of a particular country or region. For example, in 2000, in the African Region, an estimated 725,000 people died due to injuries, accounting for 7% of all deaths within the region and 15% of worldwide injury-related deaths. Of these injuries, road traffic injuries, war and interpersonal violence were the leading causes, accounting for 59% of the total (see Figure 1).



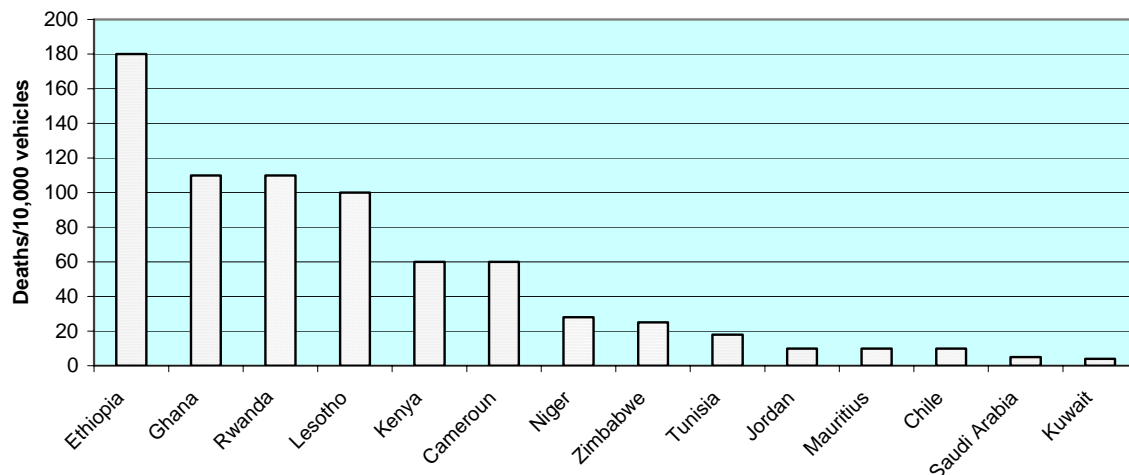
Source: Adapted from: M. Peden et al, The injury chartbook: a graphical overview of the Global burden of injuries, World Health Organization, Geneva, 2002.

<sup>3</sup> See World report on violence and health, WHO, Geneva, 2002.

12. Road traffic crashes are becoming an increasingly common cause of unintentional injuries globally. With over one million people being killed and over 20 million being injured or disabled each year in road traffic crashes, it is the ninth major cause of death and disability adjusted life years lost worldwide. It is expected to become the third major cause of death by 2020.

13. During the last three decades, the mortality rate from road traffic injuries in Africa has become the highest in the world (see Figure 2). The most affected groups of people are pedestrians, passengers and cyclists. Some of the contributing factors are inadequate road design, excessive alcohol consumption, speeding, under-utilization of seat belts and child restraints, unsafe vehicular design, poor maintenance of vehicles and roads, insufficient training of vehicle users and a lack of implementation of road safety regulations. The financial cost of road traffic injuries in the African Region was estimated at 1% of GDP, or US\$ 3,700 million<sup>4</sup>.

**Figure 2: Traffic deaths/10,000 vehicles/year in selected countries, 1985–1986**



Source: Adapted from: P. Brass et al, Injury prevention: An international perspective; epidemiology, surveillance and policy, New York, Oxford University Press, 1998.

14. Other types of unintentional injuries common in the Region include drowning, burns, poisoning and falls. Of deaths due to unintentional causes, drowning is the second leading cause after road traffic injuries, generally with higher rates in rural areas. The African Region also has the highest death rate due to fire-related burns, with most of these occurring among children aged 0 to 14 years. Poisonings and falls result in death and disability especially among children 0 to 4 years.

<sup>4</sup> Jacobs GD et al, Estimating global road fatalities, London, Transport Research Laboratory, 2000.

15. Violence accounted for an estimated 1.6 million deaths worldwide in the year 2000. In Africa, 37% of all injury deaths were due to violence, and the death rate from violence in Africa (60.9 per 100,000 population) was twice the global rate and substantially higher than for the Latin American and Eastern European regions.

16. In Africa, in the year 2000, there were an estimated 116,000 deaths due to interpersonal violence; 27,000 deaths due to self-directed violence (suicide); 167,000 deaths due to collective violence. Almost half of these deaths occurred among young males in the economically active age range of 15 to 44 years. Non-fatal outcomes of collective violence are likely to be substantial given that the ratio of injured to killed among military personnel across a wide range of conflict settings has been reported to vary from 1.9 to 13.

17. Intimate partner violence occurs in all societies and Africa is no exception. UN statistics show that a third of all women experience intimate partner violence in their lifetime. Intimate partner violence increases the occurrence of physical injury, mental health disorders, substance abuse and attempted suicides. Girls and women are also subject to high levels of sexual violence including rape, child marriage and child trafficking. Harmful traditional practices include female genital mutilation, which is known to be prevalent in 27 of the 46 Member Countries in the Region.

18. Intimate partner violence and child abuse often occur in the same families and are associated with similar individual, relationship, community and societal risk factors. Moreover, children growing up in violent families are more likely to engage in youth violence.

19. Youth violence, mainly involving males aged 10–29 as victims and perpetrators, underlies the high rates of homicide in the African Region. It is also a major drain on hospital resources; studies from all over the world reveal that for every homicide there are 20 to 40 victims of non-fatal violence receiving hospital treatment. Homicides due to youth violence are closely correlated with economic inequalities and firearm availability; underlying causes are rooted in infant and early childhood exposure to family violence and inadequate parenting, and in adolescence with delinquent and violent peers.

20. Elder neglect was previously seen as a social welfare issue and a problem of aging; however, it is now seen as a form of family violence and has developed into a public health concern.

21. War-related injuries account for the second highest number of injury-related deaths in Africa. In 1997, there were 25 new conflicts identified in the Region. A variety of studies indicate that the proportion of non-combatants among those killed as a direct result of conflict is likely to exceed 50%. Many who survive direct injury are permanently disabled and suffer from a variety of psychosocial sequelae.

22. Collective violence destroys infrastructure and disrupts vital services such as medical care, trade and food production. These effects undermine livelihood strategies and widen socio-economic inequalities. Forced displacement arising from conflicts has dire consequences for the poor, elderly, ill or disadvantaged.

23. Collective violence creates conditions of insecurity, which favour increasing availability of firearms. A substantial proportion of the 262 million firearms in illicit circulation globally is likely to be circulating within Africa. Availability of firearms correlates closely with measures of a number of forms of violence and the resulting mortality. In addition, the ease of access to these weapons has a rational attraction for those who feel the state cannot protect them or for those who see an opportunity to earn a livelihood through violent means.

24. Many African countries have a high number of victims of landmines and other forms of unexploded ordnance (UXO). Use of these forms of weaponry in a wide range of conflicts has led to a legacy of continued and indiscriminate injuries and death. For instance, over 2,000 casualties of landmine and UXO detonations were reported for Angola between 1998 and 2001, many of these resulting in death or permanent disability. Recent statistics for Angola indicate a continued toll of approximately 55 new casualties per month.

25. Suicides, both completed and attempted, are acts of violence against oneself. Over 800,000 people worldwide killed themselves in 2000. Among those aged 15 to 44 years, self-inflicted injuries are the fourth leading cause of death and the sixth leading cause of disability. Available studies show cultural and environmental differences related to suicide and suggest that suicide may increase with social and economic changes.

26. For all injuries, the number of deaths for every non-fatal incident appears to be higher in Africa and some other developing regions of the world than in developed regions. Poor and underdeveloped pre-hospital and hospital care systems are important contributing factors to this high fatality rate. In most countries of Africa, victims have little chance of receiving emergency care at the scene or of being transported to a hospital by ambulance. Hospitals are often poorly equipped (training, education, resources) to deal with the demands of injured trauma patients.

27. The scale of the problem of violence and injuries includes the disproportionately heavy burden of death and disability on the disadvantaged in society as well as the costs to individuals, the health care system and society in general. Injuries and violence are a public health concern not only because of their broad impact on societies but also because public health can offer solutions to prevent them. Through a variety of measures targeted at individuals, families and communities, the health sector has a vital role to play in this field.

### **AGENDA FOR ACTION**

28. The health sector should promote evidence-based preventive measures; improve pre-hospital care, hospital care and rehabilitation programmes; undertake surveillance; and reinforce the role of research. The sector should also mobilize and support others in advocacy, policy development and coordination.

29. The health sector has a pivotal role in increasing awareness among individuals, communities, social services, local and regional governments, and donors regarding injury and violence as a public health problem and the opportunities that exist for prevention.

30. Coordination of the diverse groups of individuals and organizations involved is necessary for effective injury and violence prevention. These efforts should involve individuals, communities, governments and nongovernmental organizations, encourage more efficient broad-based partnerships and reinforce the role of pre-emptive research.

## **ROLES AND RESPONSIBILITIES**

### **Responsibilities of countries**

31. Among other prerequisites, improvement in health requires a secure foundation in peace. The prevention and non-violent resolution of conflicts is an opportunity in the achievement of health for all and the millennium development goals (MDGs). Countries should endeavour to invest in sustaining peace and preventing or solving conflicts.

32. Countries should adopt and implement relevant policies, strategies and programmes.

33. Concrete steps should be taken to raise awareness. Intersectoral approaches (policy measures, law enforcement, environment change, education) should be adopted to formulate and implement preventive and protective measures, including emergency and disaster preparedness and the use of health promotion strategies.

34. Injury and violence prevention should be the key component of a national policy, which should be the result of a national consensus building process. Such policy needs to be consistent and in compliance with international agreements such as the International Convention on the Rights of the Child. The availability of global technical documents (such as the *WHO World report on violence and health*) with clear recommendations will facilitate the process. The policy must make provision for appropriate legislation and law enforcement. Particular emphasis should be placed on road traffic safety, interpersonal relationships and prevention of collective conflicts.

35. The consequences of injury can be minimized by providing first aid, life-sustaining care soon after injury. Most immediate care methods are easy to teach and do not require medicines or specialized equipment. Early and safe transportation of the injured to a casualty care centre is a key component in reducing the consequences of injury. Thus, the primary health care system, including community-based prevention and rehabilitation programmes, can play a very important role in the prevention and control of injuries.

36. Ministries of health should develop, implement and evaluate the information system for injury and violence prevention. The data generated should be used to set priorities and prevention programmes at all levels.

37. The health sector should assess and strengthen the capacity and infrastructure for addressing injuries and violence, including surveillance, training, pre-hospital and hospital care, community emergency response and rehabilitation.

38. Research is needed to bridge the information gap, identify the determinants of injury and violence in specific contexts, and measure the effectiveness of preventive and curative interventions.



39. Countries should enhance or build partnerships involving governmental agencies as well as bilateral and multilateral organizations, civil society and the private sector. These partnerships should be used to increase the visibility of violence and injury prevention as a priority and to coordinate activities for prevention and control.

#### **Responsibilities of WHO and other multilateral and bilateral partners**

40. These include:

- (a) development of guidelines and tools for advocacy, information systems, pre-hospital and hospital care, rehabilitation services, and disaster preparedness and management.
- (b) support to countries to mobilize resources for primary prevention of injuries and violence, and develop partnerships and networks.
- (c) support to national and regional research into the causes, risk factors and consequences of injuries and violence; use research results to promote prevention strategies.
- (d) documentation and dissemination of examples of best practices which are interventions that have been proven to be effective through scientific evaluation of their impact on the target problem.
- (e) assistance to Member countries with the implementation and monitoring of appropriate information systems.

#### **MONITORING AND EVALUATION**

41. The following will be used to facilitate monitoring of progress in the achievement of injury and violence prevention and control at country level:

- (a) development and adoption of a comprehensive policy by countries and ministries of health;
- (b) adoption of legislation and issuance of regulations to improve safety and protect individuals and communities against evident risk factors of injury;
- (c) establishment of a surveillance system for data collection, analysis and dissemination;
- (d) incorporation of injury and violence prevention and control aspects, including emergency preparedness, in all health system development programmes (human resources, infrastructure, resource allocations, research);
- (e) establishment of formal mechanisms of coordination and collaboration between different stakeholders and partners, including communities.

#### **CONCLUSION**

42. Despite the gaps in information and knowledge, experience to date has taught some important lessons about preventing injury and violence and mitigating their consequences. Injury and violence are often predictable and preventable. Political commitment to tackling

injury and violence is vital to the public health effort. While much can be achieved by grassroots organizations, individuals and institutions, the success of public health efforts ultimately depends on political commitment. This is as vital at the national level where policy, legislative and overall funding decisions are made as it is at the provincial, district and municipal levels where responsibility of day-to-day administration of policies and programmes rests.

43. The Regional Committee is invited to consider this document and endorse the proposed agenda for action.