Policy briefing 08

Using advocacy for injury prevention

Background

In the 53 countries of WHO European Region every year intentional and unintentional injuries kill nearly 800,000 people. They are the leading cause of death for people under 45. This is only the most visible part of their burden (World Health Organization, 2008). For every injury–related death, it is estimated that there are 30 people admitted to hospital and 300 who need treatment in hospital emergency room departments and much more untreated or seeking help through general practitioners. Similar figures are valid for children (Sethi et al., 2008b). Costs to health sector and society are huge, estimated at billions of euro every year. Societal costs for road traffic injuries alone have been estimated at 2% of Gross Domestic Product. The burden of injuries falls disproportionately on more vulnerable groups, such as children and elderly. There are large inequalities in the distribution both between countries and within countries. While some western European countries are among the safest in the world, higher rates can be observed in the eastern part of the Region because of worst socioeconomic conditions and environmental exposures. It has been estimated that, if the lowest European injury rate was observed everywhere, around 500,000 lives could be saved, that is the 68% f the observed injuries (Sethi et al., 2006a, Sethi et al., 2006b). This indicates cost-effective strategies exist and have been successfully applied (Krug, E, Dahlberg & Mercy, 2002, Peden, M et al., 2008, Peden, M et al., 2004a, Sethi & Butchart, 2008, Sethi, Racioppi & Mitis, 2007) and that injuries are not unavoidable and can be prevented through a public health approach. Advocacy is needed in order to highlight this argument to policy makers and civil society and that greater societal and political priority should be given to prevention.

This policy briefing sets out to define advocacy, discuss why advocacy is needed in violence and injury prevention, provides international and national examples of advocating across the sectors and with the public, and then concludes with some generalisable lessons for action.

Definition of advocacy

Advocacy for health has been defined by WHO as “a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme.” (*Report of the Inter-Agency Meeting on Advocacy Strategies for Health and Development: Development Communication in Action*, 1995). Such action may be taken by and/or on behalf of individuals and groups to create *living conditions* which are conducive to *health* and the achievement of healthy *lifestyles.* Advocacy is one of the three major strategies for *health promotion* and can take many forms including the use of the mass media and multi-media, direct political lobbying, and *community* mobilization through, for example, coalitions of interest around defined issues. Health professionals have a major responsibility to act as advocates for *health* at all levels in society (World Health Organization, 1998).

Why is advocacy needed in injury and violence prevention

As stated in a recent paper (Breen, 2004), advocacy can be used as a tool to fill the gap between what is known to be effective and what is practised. Good practices to reduce the burden of injury and violence exist and they have been proven to be cost-effective. Often they are not applied because they are considered as a low priority by policy–makers who have competing issues on their agendas, and which have with few resources allocated, and because they encounter severe barriers to their application. The strength of interest groups, opposition groups and lobbies is the first obstacle that often advocacy has to win. Good examples can be found both in unintentional and intentional injuries field. Road safety advocacy, for example, has to face the opposition of both alcohol industry, that is against the random breath testing or the reductions in legal blood alcohol limits for driving, and car industry which can delay the application of vehicle safety legislation. In violence prevention strong opposition comes from lobbies sustaining the right to own a weapon as a right to self-defence. To give evidence of cost-effectiveness to policy makers, the involvement of several stakeholders is needed: groups of– and single health professionals, academics, NGOs, committees of private citizens, non-profit organizations, international, national and local institutions, other sectors, product safety associations, every group that aims to campaign for change, influence opinion, contribute to debate, educate and inform on the promotion of safety and the prevention of injuries.

APOLLO

Advocacy at the international level

At the international level the World Health Organization pushes countries and governments to adopt a public health multidisciplinary approach for the prevention of injuries. These have been put higher in public health agenda through several resolutions from the World Health Assembly (World Health Assembly resolution WHA56.24 on implementing the recommendations of the World report on violence and health, 2003) (World Health Assembly resolution WHA57.10 on road safety and health, 2004) and from the WHO Regional Committee for Europe (World Health Organization, 2005). Several reports have been published which have been authoritative documents summarising the best evidence and include: World report on violence and health (Krug, EG. et al., 2002), World report on road traffic injury prevention (Peden, M. et al., 2004b, Racioppi et al., 2004), Youth and road safety in Europe (Sethi, Racioppi & Mitis, 2007) and the World (and European) report (s) on child injury prevention (Peden, M et al., 2008, Sethi et al., 2008b). An on-going European Commission and WHO Europe project (Sethi et al., 2008a) is taking advocacy into action by working with health ministries to implement the WHO Regional Committee resolution jointly with the European Council Recommendations (European Council, 2007). Another example is the EC funded project Child Safety Action Plans which advocates for greater action in the area of child injury prevention by working with civil society to develop national plans and advocate for change (Mackay et al 2006).

Using international campaigns for advocacy at the national level

At national level, government-sponsored advocacy campaigns should inform people about the main injury and violence problems in the country and how these can be prevented. They should also correct public misconceptions surrounding the causes and preventability of injuries and violence. Such campaigns should be coordinated with the introduction of new laws and policies, so as to increase public awareness of them. Information campaigns can accompany prevention efforts, highlighting, for instance, the unacceptability of violence against women and children or the importance of smoke detectors. Launches of new policies, programmes or publications on injury and violence often provide good opportunities for ministries of health to conduct advocacy efforts.
Campaigns can also be built around high-profile events on the global calendar, such as:

- United Nations Global Road Safety Week;
- International Day for the Elimination of Violence against Women;
- International Day of Disabled Persons;
- World Day of Remembrance for Road Traffic Victims.

Involving prominent public figures and the local and national media in campaigns built around these events can boost their impact. If well planned and executed, these campaigns can help health ministries build broad coalitions for action. It is important, though, to state that stand-alone information or publicity campaigns that are not linked to other longer-term interventions will generally not deliver significant and sustained reductions in violence and injury.

Advocating at the national level

Not all these campaigns work. The efficiency of advocacy varies, by country, according to the power of interest groups. Ten years were needed, for example, in the United Kingdom to make seat-belts compulsory, and the price paid was high in terms of life lost (Breen, 2004), because of the opposition of a leading motoring organisation and of active minorities that identified in that measure the state interference in civil liberties. The British Medical Association, the Casualty Surgeons Association, the Royal College of Surgeons, the British Paediatric Association, and the Child Accident Prevention Committee (now trust) formed the coalition that eventually helped to get this measure into the Transport Act 1981. The measure passed despite the strong opposition from both the prime minister and the leader of the opposition at the time and although the final free vote was scheduled on the eve of the wedding of the heir to the throne (Breen, 2004). Strong opposition are still met, for the same reasons, even though they were proven to be effective, for speed cameras and to decrease the blood alcohol limit for which the British Medical Association is struggling since the late 80s.

The power of the opposition lobbies can be an obstacle as demonstrated in the case of regulating for gun use. In the United Kingdom, after two massacres caused by gun owners, was relatively easy, under the pressure of the Gun Control Network, to study and apply a strict gun law in 1997 by which, for instance, internet gun sales were monitored and even Olympic's shooters could only train abroad. Although several associations in favour of gun ban exist in the United States of America (for example, "Mothers against guns" or the "Violence policy centre"), a similar achievement is unreachable in the United States of America for the strong opposition of the National Rifle Association.

At national level, advocacy action can be effective in absence of EU regulations or to push governments to apply EU directives in the due terms. As there is no EU standard, Portugal government, pushed by the Portuguese Association for Child Safety, is preparing a national standard for balconies and stairs/barriers/guardrails in buildings with the support of a multidisciplinary technical committee mandated by the national government. One of the agreed principles is that barriers must protect young children. The same association is forcing Portuguese government to reduce VAT on child passenger restraint systems, as recommended by EU directive, from 21 to 5% the same value of the tax on soft drinks.

Applying principles of prevention in the field of injuries and violence is an unfamiliar approach for many government ministries. Health ministry advocacy towards other government sectors therefore needs to explain the need to confront injury and violence and the advantages of the public health approach. In this respect the Tallinn charter emphasizes the importance of strengthening the stewardship role of the health sector in working with other sectors (WHO 2008). The health sector can influence other sectors by working through seminars, workshops and newsletters, and by inviting relevant groups to discuss their roles and responsibilities in prevention. Health ministries should employ the data they collect to inform decision-makers about the nature and scale of injuries and violence in their countries – including epidemiological data on the issue, the direct and indirect economic costs of injuries and violence, and proven and promising prevention measures. Ministries of health also sometimes need to call for government ministries, United Nations agencies and NGOs to collaborate on a particular health topic. Mobilizing a range of agencies in this way behind a common cause is itself a productive exercise. With both types of advocacy, ministries of health should fully use all the resources available to them.
These include local data, as well as the WHA and WHO Regional Committee resolutions on injuries and violence and the WHO World reports and their recommendations.

Nongovernmental organizations are another powerful ally for health ministries to draw on in conducting advocacy. Indeed, in many countries, groups of victims of violence or road traffic injuries or of unsafe products and their families are among the most vigorous in campaigning for prevention. Several times a local private initiative, due, for example, to the loss of relatives because of unsafe products, became active and operative at national level, thanks to the collaboration with the health sector. Good examples of how partnerships between survivor advocates and injury prevention professionals, can be found in "Kids in Danger, the Danny's Foundation, Drowning Prevention Foundation and Stop for Kids Safety (Injury Prevention Newsletter, volume 13). Such groups have also been active in pressing for stronger controls over firearms, action against sexual and child abuse, and improved legislation on road safety. Tragic incidents – such as suicides, shootings in schools or the violent death of a well-known person – often trigger huge public concern. If this concern is effectively channelled, it can produce a rapid and sustained increase in political commitment to primary prevention. Wherever appropriate, health ministries should support such nongovernmental efforts so as to further injury and violence prevention.

Also private initiatives of health professionals led to the foundation of organizations that became, by building partnership and by providing credible programs and messages, national leader in promoting and disseminating effective prevention strategies for unintentional injuries. For instance, Safe Kids Canada works with over 1,800 partners at national level to educate parents on major causes of injury and death and the simple measures available to protect their children. An evidence-based approach is translated into good practices to reduce the number of children hurt or killed by preventable injuries. These practices include using bike helmets and booster seats, checking hot water temperatures and banning baby walkers (ref website).

The role of health professionals advocating the public is crucial. Physicians advocating for safety measures by counseling to raise awareness against specific hazards supported by evidence of effectiveness and advocate for the control of hazards that markedly increase the risk of serious injury such as baby walkers. But health professionals are crucial also when working with other child safety advocates. In Canada, for example, baby walkers were banned in 2004 thanks to a joint action of paediatricians and child safety advocates (the Health Canada's Mechanical and Electrical Division of Consumer Product Safety, Safe Kids Canada). The decision to ban them resulted from scientific analysis of data collected through Health Canada's Canadian Hospital Injury Reporting and Prevention Program.

Conclusions

Violence and injuries account for 9% of global mortality and 16% of global disability, and are increasingly seen as a major public health issue. Prevention work by governments has expanded, but ministries and practitioners need to advocate for greater action. This briefing has highlighted some of the issues. In this respect advocating for the prevention of injuries and violence is a sound public health objective because they are preventable. Advocates need to work with stakeholders and emphasize that injury and violence prevention is a win-win situation (Chapman 2004). Opposition groups have to be encountered effectively. International advocacy efforts can be harnessed effectively at the national and local level to take forward this important but until recently neglected area of public health and ensure that stakeholders are clear about their responsibilities in preventing injuries and violence.

References

1. Breen J (2004). Road safety advocacy. British Medical Journal, 328:888-890Z.

2. Council recommendation of 31 May 2007 on the prevention of injury and promotion of safety. European Council, 2007 (http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwVwContent/l3councilrecommendation.htm, accessed 22 August 2008).

3. Chapman S. Advocacy for public health: a primer. JECH 2004;58:361-5.

4. Krug E, Dahlberg L, Mercy J (2002). World report on violence and health, Geneva.

5. Krug E et al., eds (2002). World report on violence and health. Geneva: World Health Organization.

6. Mackay M, Vincenten J. Action planning for child safety: a strategic and coordinated approach to reducing the number one cause of death for children in Europe. Amsterdam, European Child Safety Alliance (EuroSafe), 2007.

7. Peden M et al. (2008). World report on child injury prevention. Geneva: WHO and UNICEF.

8. Peden M et al. (2004a). World report on road traffic injury prevention. Geneva: World Health Organization.

9. Peden M et al., eds (2004b). World report on road traffic injury prevention. Geneva: World Health Organization.

10. Racioppi F et al. (2004). Preventing road traffic injury: a public health perspective for Europe, WHO Regional Office for Europe, Copenhagen.

11. Report of the Inter-Agency Meeting on Advocacy Strategies for Health and Development: Development Communication in Action (1995). WHO, Geneva.

12. Sethi D, Butchart A (2008). Violence/Intentional Injuries - Prevention and Control. In: Heggenhougen HK, Quah SR, eds. International Encyclopedia of Public Health, vol. 6. San Diego: Academic Press; p. 508-518.

13. Sethi D et al. (2006a). Reducing inequalities from injuries in Europe. Lancet, 368:2243-2250.

14. Sethi D et al. (2006b). Injuries and violence in Europe. Why they matter and what can be done, WHO Regional Office for Europe, Copenhagen.

15. Sethi D et al. (2008a). Progress in preventing injuries in the WHO European Region, WHO Regional Office for Europe, WHO European Centre for Environment and Health, Copenhagen.

16. Sethi D, Racioppi F, Mitis F (2007). Youth and road safety in Europe, WHO Regional Office for Europe, WHO European Centre for Environment and Health, Copenhagen/ Rome.

17. Sethi D et al. (2008b). European report on child injury prevention, WHO Regional Office for Europe, WHO European Centre for Environment and Health, Copenhagen.

18. World Health Assembly resolution WHA56.24 on implementing the recommendations of the World report on violence and health (2003). World Health Organization, Geneva.

19. World Health Assembly resolution WHA57.10 on road safety and health (2004). World Health Organization, Geneva.

20. World Health Organization (1998). Health promotion glossary, Geneva.

21. WHO Regional Committee for Europe resolution EUR/RC55/R9 on prevention of injuries in the WHO European Region. World Health Organization, 2005 (http://www.euro.who.int/eprise/main/WHO/AboutWHO/Governance/resolutions/2005/20050922_1, accessed 28 October 2008).

22. The global burden of disease: 2004 update [web site]. World Health Organization, 2008 (http://www3.who.int/whosis/menu.cfm?path=whosis,burden,burden_estimates,burden_estimates_2002N, accessed 10 November 2008).

(Published in January 2009)

Partners

Acknowledgements

Apollo is a project that is co-sponsored by the European Commission in the framework of the Public Health Programme (Grant Agreement 2004119). The project aims to identify strategies and best practices for the reduction of injuries within the EU and is led by the Centre for Research and Prevention of Injuries (CEREPRI) of the University of Athens. This document has been produced by EuroSafe, in collaboration with the WHO European Centre for Environment and Health, within the framework of work package 6 of Apollo.

It has been written by Dr. Dinesh Sethi and Dr. Francesco Mitis, World Health Organization, Regional Office for Europe, Rome, Italy.