INJURY ISSUES MONITOR

In this issue ...

WHO releases report on Violence

Launched in October of this year, the *World Report on Violence and Health* is the first comprehensive report of its kind to address violence as a global public health problem. A substantial document of more than 370 pages, the report took 3 years to compile and drew on the participation of 160 experts from around the world.

According to the Report, violence kills more than 1.6 million people every year. In addition to the deaths, millions of people are left injured as a result of violence and suffer from physical, sexual, reproductive and mental health problems. Public health experts say the majority of violent acts are being committed behind closed doors and going largely unreported. This report aims to shed light on these acts.

The death and disability caused by violence make it one of the leading public health issues of our time. Violence is among the leading causes of death for people aged 15-44 years of age, accounting for 14% of deaths among males and 7% of deaths among females. On an average day, 1,424 people are killed in acts of homicide—almost one person every minute. Roughly one person commits suicide every 40 seconds. About 35 people are killed every hour as a direct result of armed conflict. In the 20th century, an estimated 191 million people lost their lives directly or indirectly as a result of conflict, and well over half of them were civilians. Studies have shown that in some countries, health care expenditures due to violence account for up to 5% of GDP.

Throughout its various sections that span youth violence, child abuse and neglect, violence by intimate partners, abuse of the elderly, sexual violence, suicide and self-harm, and collective violence, the new report shows how Australia fares in relation to other countries across the Globe. The following brief extracts provide an example of this:

- Intimate partner violence occurs in all countries, irrespective of social, economic, religious or cultural group. Although women can be violent in relationships with men, and violence is also sometimes found in same-sex partnerships, the overwhelming burden of partner violence is borne by women at the hands of men. In

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Editorial

During the past 10 to 20 years, violence has come to be acknowledged as falling within the area of interest and responsibility of injury prevention. Suicide, other self-directed harm and interpersonal violence once tended to be seen as being outside the scope of what was often described as 'accident prevention'. In Australia, the Better Health Commission's 1986 report marked a clear recognition that violence is a matter for public health and injury prevention.

Globally, the *World Report on Violence and Health*, published by the World Health Organization in October 2002, is a similar marker of maturing recognition that violence prevention is part of the business of public health and injury prevention. This work is an outcome of the new direction signalled by the 1996 World Health Assembly resolution *Preventing violence: a public health priority*. The resolution, co-sponsored by Australia and South Africa, was developed by a consultative process during the 3rd International Conference on Injury Prevention and Control at Melbourne in February 1996. Fittingly, South Africa's president when the resolution was made, Nelson Mandela, has written the foreword to the new WHO report.

Why should health workers and injury preventionists take on the issue of violence? At one level the answer is obvious: violence is a major cause of fatal and non-fatal injury and poisoning and associated pain, disability and cost. The WHO report provides the most comprehensive overview yet of violence throughout the world.

What can we contribute to this aspect of injury prevention? To start with, methods for quantifying, describing and coming to understand the causes of injury which work for non-intentional injury are often just as useful for injury resulting from violence. It has become clear that risk factors and mechanisms of injury have considerable similarities, whether or not they result from overt violence and distinctions between 'intentional' and unintentional' injury are often far from sharp. Most importantly, there is increasing recognition that approaches to prevention can be effective against injury from violence as well as against other injury. This is a major theme of the WHO report.

The terrorist bombings in Bali occurred

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WHO releases report on Violence

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48 population-based surveys from around the world, between 10% and 69% of women reported being physically assaulted by an intimate male partner at some point in their lives. The percentage of women who had been assaulted by a partner in the previous 12 months varied from 3% or less among women in Australia, Canada and the United States to 27% of ever-partnered women (that is, women who have ever had an ongoing sexual partnership) in Leo'n, Nicaragua, 38% of currently married women in the Republic of Korea and 52% of currently married Palestinian women in the West Bank and Gaza Strip.

- Data from a wide range of countries suggest that partner violence accounts for a significant number of deaths by murder among women. Studies from Australia, Canada, Israel, South Africa and the USA show that 40-70% of female murder victims were killed by their husbands or boyfriends, frequently in the context of an ongoing abusive relationship. This contrasts starkly with the situation of male murder victims. In the USA, for example, only 4% of men murdered between 1976 and 1996 were killed by their wives, ex-wives or girlfriends. In Australia, between 1989 and 1996, the figure was 8.6%.
- National suicide rates vary considerably. Among countries reporting suicide to the WHO, the highest suicide rates are found in Eastern European countries (eg Belarus 41.5 per 100,000, Estonia 37.9 per 100,000, Lithuania 51.6 per 100,000 and the Russian Federation 43.1 per 100,000). High rates of suicide have also been reported in Sri Lanka (37 per 100,000 in 1996). Low rates are found mainly in Latin America (notably Colombia 4.5 per 100,000 and Paraguay 4.2 per 100,000) and some countries in Asia (eg the Philippines 2.1 per 100,000 and Thailand 5.6 per 100,000). Countries in other parts of Europe, in North America and parts of Asia and the Pacific tend to fall somewhere in between these extremes (eg Australia 17.9 per 100,000, Belgium 24.0 per 100,000, Canada 15.0 per 100,000).
- In Australia, the youth homicide rate declined from 2.0 per 100,000 in 1985 to 1.5 per 100,000 in 1994, while in neighbouring New Zealand it more than doubled in the same period, from 0.8 per 100,000 to 2.2 per 100,000. In Japan, rates in the period stayed low, at around 0.4 per 100,000.

Although the statistics are chilling, the situation is judged to be far from hopeless. In the words of Dr Etienne Krug, Director of the WHO's Department of Injuries and Violence Prevention, "There is nothing inevitable about violence, nor is it an intrinsic part of the human condition." As a complement to the law and order approach to violence, the report promotes a public health understanding of the complex social, psychological, economic and community underpinnings of violence. While recent research suggests that biological and other individual factors may explain some of the predisposition to aggression, these factors more often interact with family, community, cultural and other external factors to create a situation where violence is likely to occur. Understanding these situations and these causes creates opportunities to intervene before violent acts occur, providing policy-makers with a variety of concrete options to prevent violence.

Among the recommendations for prevention made by the report are primary prevention responses such as preschool and social development programs for children and adolescents, parent training and support programs and measures to reduce firearm injuries and improve firearm safety. Other recommendations include strengthening responses for victims of violence, promoting adherence to international treaties and laws and improving data collection on violence.

The complete report, or a summary of it, can be downloaded from the WHO website:

www.who.int/health_topics/violence/en/

A number of fact sheets are also available for downloading from the above site: Youth violence; Child abuse; Intimate partner violence; Elder Abuse; Sexual Violence; Self-directed violence; Collective violence.

Printed copies can be ordered. Within Australia, they are available from Hunter Publications, Tek Imaging, PO Box 404, Abbotsford VIC 3067, Tel: 03 9417 5361; Fax 03 9419 7154, E-mail: admin@tekimaging.com.au

Editorial

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just over a week after the WHO report was released. This horrific act killed about as many Australians as do all homicides in Australia in a typical three month period, and injured many of the survivors. Can there be useful injury prevention responses to terrorism and mass violence? What forms can they take? The answer to the first question must surely be 'yes'. The answers to the second are diverse, and will take some time to become clear. For example, surveillance is a basic tool for public health, including injury prevention. Some forms of surveillance have potential for early warning of some types of terrorism. The US Centers for Disease Control have recently funded a pilot program for early warning of terrorism related illness. The knowledge and methods of injury preventionists can be used during the evaluation of events to improve prevention and preparedness in future. A very different form of preventative response to mass violence is exemplified by the Medical Association for the Prevention of War and the organisations working against anti-personnel landmines.

Statistical data in the WHO report shows that, overall, Australia is far from the worst, but by no means the best, in terms of mortality and morbidity due to violence. Suicide rates are similar to comparable countries and homicide rates are relatively low. While much more could be done, Australia is a country in which many preventive responses to violence exist. However, overall figures can hide pressing problems of violence in particular groups, such as some Aboriginal communities, and some aspects of violence are still not well recognised.

As the WHO report and the Bali bombs make plain, injury due to violence does not stop at Australia's borders and nor do reasons to work towards prevention. The first Asia-Pacific Injury Prevention Conference, to be held in Perth in March 2003, will provide an opportunity for practitioners, policy-makers and researchers in Australia and the region to develop understanding of and responses to violence.

Older Australia at a glance

The Australian Institute of Health and Welfare (AIHW) recently released the third edition in its series *Older Australia at a glance*, which takes account of continuing advances in Australia's data and policies on ageing and aged care.

The report is a joint venture between the AIHW and the Commonwealth Department of Health and Ageing.

Population changes

At 30 June 2001, there was an estimated 2.4 million people in Australia aged 65 years and over (12.5% of the total population of 19.4 million). This represents 22% growth since 1991 when there were 2 million older Australians. The growth in the older population is set to continue. ABS projections are that by 2011, the 65+ population will exceed 3 million (14% of a total population of 21,288,800) and by 2021 it will be around 4.2 million (18% of a total of 22,926,400).

As well as increasing in absolute numbers, and as a proportion of the total population, the older population is also changing in its internal age structure. In 1991, the proportion of older people who were aged 85 and over was 8%; in 2001 it was 11%. Between 1991 and 2001, the 85 and over population increased more rapidly than other groups (10% for those aged 65-74, 36% for those aged 75-84 and

69% for those aged 85 and over). Between 2011 and 2021 this will begin to change as the baby boom generation enters the 65 and over age groups. In that decade, the rates of increase are projected to be 28% of those aged 65-74, 17% for 75-84 and 50% for those aged 85 and over. In this decade, the ageing of the aged population which has been strongly evident since 1981 will begin to reverse, giving way in the cycle of population change to a 'younging' of the aged population.

Another expected change is that the ratio of men to women in the older population will increase, although older women will still outnumber men.

Other expected changes include a decline in the number of veterans in the older population and, with some exceptions, the population in rural and remote areas is expected to age at a greater rate than the population in metropolitan areas.

Main causes of death

The main causes of death for both women and men aged 65 and over are diseases of the circulatory system, cancers and diseases of the respiratory system, with those accounting for over three-quarters of all deaths among people in this age group. In fourth place is injury and poisoning, accounting for 2.3% of deaths in the age group during 2000. However, the death rate from accidental falls is substantially higher in people aged 75 and older compared with the 65-74 age group, for both men and women.

Hospital use

In the 12 month period 2000-01 there

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Elderly falls: NSW plans for increased service demand

Upon retirement, older people in NSW often change residence. Many retirees often seek a warmer climate near water. Some rural residents move to larger towns and cities to be closer to health and other services. Falls prevention and associated health care resources need to be allocated to where older people choose to live.

NSW health services are administered through 17 separate Area Health Services (AHS). Each AHS has responsibility for the needs of several Statistical Local Areas (SLAs). The Central Sydney AHS, for example, oversees 9 SLAs.

The NSW Health Department has recently completed a project to identify where resources for falls prevention are likely to be needed in the next 15 years. Information for each AHS and each SLA has been generated regarding:

- population projections by age group;
- fall-related bed day projections by age group; and
- fall-related health service costs and utilisation.

A series of documents has resulted. Prepared by NSW Health's Injury Prevention & Policy Unit to assist Area Health Services, these documents identify the impact of fall injury on the demand for services and how this will change as the population of NSW ages. Indicators in the documents were supplied for each area and for each statistical local area by Jerry Moller of the South Australian based *New Directions in Health and Safety* using the NSW Inpatient Statistics Collection 1996/97 and ABS population estimates and projections. This permits an overall picture and differentiation of the varying needs and trends in local communities within each Area.

When reading the documents, careful attention needs to be paid to the definition of the indicators. There are several ways of measuring falls impacts. The ones that were chosen are likely to be consistently measurable over time but can not be taken as absolute measures of demand or cost. At the SLA level, population sizes are small. Estimates for some indicators are missing and trend data is unstable. Care should be taken to check the scales of charts and the data tables to detect these small areas. Numbers are provided in the data tables to assist with interpretation of charts.

Three indicators were selected: Population trends, Bed day demand and Costs.

Indicator 1: Population trends

The NSW population is ageing. This is happening faster in some local areas than others.

Planning resources will require an assessment of the changes in the population at risk of fall injury.

This indicator shows the changing demography of the area or SLA based on projections supplied to NSW Health

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Elderly falls: NSW plans for increased service demand

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by the Australian Bureau of Statistics. These population projections are medium projections based on the 1996 census. A chart is used in each instance to show how the highest risk older population counts are projected to change.

Indicator 2: Bed day demand

Serious falls often result in admission to hospital. This indicator shows how bed day demand is likely to change for fall related injury across all ages. The indicator is based on the bed day demand in 1996. Fall related bed days are defined as all bed days where the length of stay was greater than one day and where the external cause was identified as a fall, but excluding fractures where the cause was unknown (E887.*). This indicator was chosen because the number of single day stays in 1996 has been shown to be subject to fluctuation due to the impact of case mix funding.

Stays of more than one day have been shown to be far more stable over time and will therefore be more reliable as a time series measure. The demand figures should therefore be viewed as conservative. While all ages are included in the indicator, the major portion of bed days for fall injury is attributable to people aged 65 and over. The projections use the NSW Inpatient Statistics Collection 1996/97 and ABS population estimates and projections (HOIST, Epidemiology and Surveillance Branch, NSW Health Department).

Indicator 3: Costs and Utilisation

The Australian Institute of Health and Welfare's *Health System Costs For Injury Poisoning And Musculo-Skeletal Disorders In Australia* for 1993-1994. This publication provides exact definitions of each measure, but most are self-explanatory. The age specific per capita costs for fall injuries have been applied to the population data to provide total estimates of likely costs and service utilisation. The overall costs and utilisation numbers have been adjusted to account for multiple conditions so that over all causes they add up to the national totals.

The bed day estimates in this indicator therefore reflect the number of bed days required if national levels of service are provided and they are corrected to account for the bed days attributable to co-morbid conditions. This adjustment was not possible for bed day totals provided in Indicator 2. It should be expected that the bed day totals in this indicator would be lower than in Indicator 2. The difference however is not consistent across areas or localities, suggesting that there are other factors at work. In particular consideration should be given to the influence of different service structures in urban, rural and remote areas.

The interpretation of other cost and utilisation measures should be made with caution, keeping in mind that these are projected national estimates, not actual local figures. The indicators are useful for assessing likely overall demand and trends.

The following summary of data collected for the Central Sydney Area, gives an idea of the kind of information that has been acquired.

Based on Australian Bureau of Statistics (ABS) projections of population trends, it appears there will be a general increase of around 8.6% in the population of people who live in Central Sydney (497,846 to 544,845 people) between 2001 and 2016.

Population trends indicate that there will be a change in population demographics for older age groups in the Central Sydney region. Population trends show that between 2001 and 2016 there will be an increase of around 3.1% of people in the 60 to 74 year age group (53,364 to 75,170 people) and a smaller growth of approximately 0.5% of people aged 75 years or older (27,605 to 32,602 people) during the same timeframe.

Considering bed day demand for fall-related injury in Central Sydney, and taking into account the change in population demographics, there is likely to be a gradual

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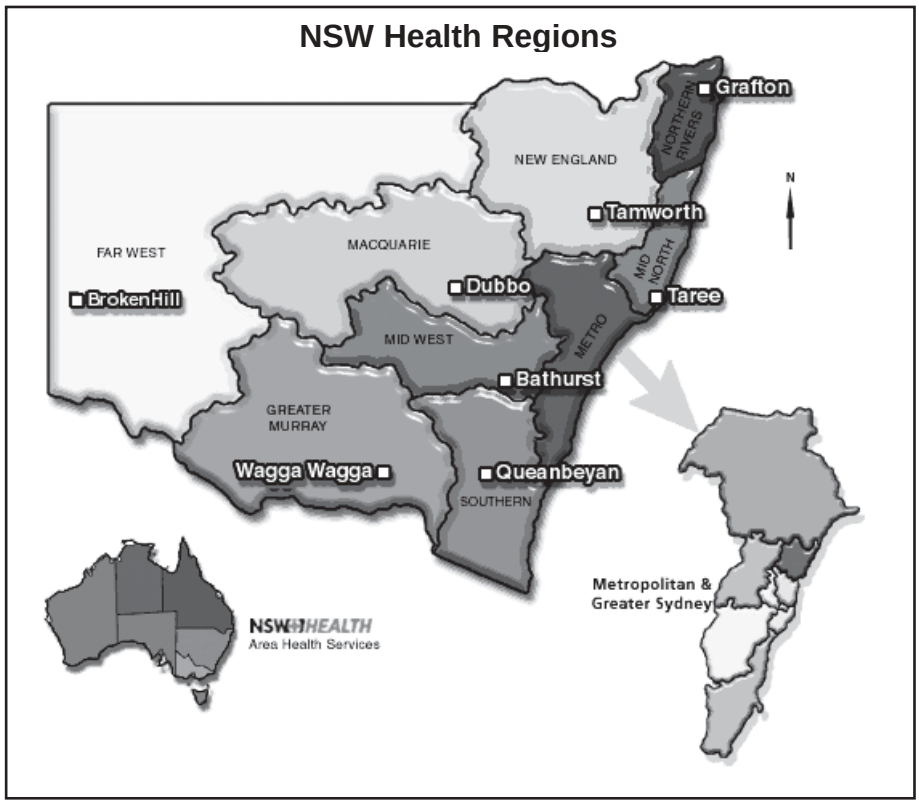

In South Australia

The South Australian Department of Human Services is currently applying the same methodology as NSW did to its own regions to help it to plan for the future.

In addition, the Department is establishing a State-wide Network to bring together all interested parties to assist it in planning for falls prevention and services.

Further information is available from Cynthia Spurr,
Tel: 08 8226 6469, E-mail: cynthia.spurr@dhs.sa.gov.au or
Bruce Surman,
Tel: 08 8226 6050; E-mail: bruce.surman@dhs.sa.gov.au

Injury prevention in Guangxi Province, China

Jerry Moller

I was invited by the World Health Organization to work with the leaders in injury prevention in Guangxi to expand knowledge of injury prevention practice and theory. The experience is one I will not forget in the most positive way. The standard of injury epidemiology and prevention and the level of commitment to make a difference impressed me. The scenery was beautiful and the hospitality very special.

One of China's five autonomous regions, Guangxi Zhuangzu, is located in the southern part of the country. It has an area of 92,700 square miles (240,100 square kilometres) and a population of 47,442,000.

Broad injury indicators for China, published by the World Health Organization (WHO)[1], show the importance of injury in China. Tables 1 and 2 show the ranking of injury mortality and burden of disease across all causes by age group.

Injury prevention is already high on the agenda and great steps have been taken to build roads to cater for increasing motorisation and to separate cycles from motorcycles and cars. Emergency services and treatment systems are in place with advanced care available at major trauma centres across the province. In Nanning, one of the major cities, motorcycles are a common mode of transport and 93% of riders wear helmets. While initially crossing the road seems hazardous, there is an air of cooperation that contributes to safety. Unlike many Asian cities, tooting horns are rare and road users of all types seem to make an effort to look after each other. The foundations of environmental controls, protective equipment and behaviour management are already well established.

L to R: Dr Xie, a newly graduated doctor in the Centers for Disease Control, Dr Jiatong Zhuo, the Assistant Director of the Guangxi CDC and the dynamo for the visit, and Jerry Moller in Guilin

Data is of high quality with deaths data and hospitalisation data collected universally from a 10% weighted sample of the population. Dr Jiatong Zhuo, Deputy Director of the Centre for Disease Control, has established a strong network for processing the data and maintains close links with researchers (including Jing Hua, whose PhD under Professor Robyn Norton in Sydney, is producing a strong basis for prevention planning), and the grass roots health services. His focus is on using the data better by involving both communities and the managers of all relevant sectors in planning for prevention. Perhaps the most impressive part of the data system is the way in which it is capable of producing aggregate data and linking through to the people of individual communities where death certificates can be viewed and local health care workers, party officials and others quickly involved in discussing possible prevention strategies.

Two major priority areas for future work were identified. Motorcycle helmets are being produced cheaply and may not always meet the necessary standards. There is concern that helmets may be failing to offer the protection they should and that this may undermine the excellent wearing rate. The major trauma centres have agreed to be involved in collecting extended data on motorcycle injuries and the CDC is designing a study to assess the size and nature of the helmet failure problem.

Drowning is a major problem in China. More than 132,000 people drown each year. Using the data from Guangxi, it was possible to view a sample of death certificates and to talk to the leaders of the Village of Hepu. Despite having a population of only 36,000, there were at least 8 drowning deaths last spring. From this micro sample it became clear that there are a number of factors involved:

- Learning to swim is difficult in natural waters where water is not clear and

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Table 1: Ranking of injury causes within the top 15 causes of mortality in China 1998

0-4 years	5-14 years	15-44 years	45-59 years	> 60 years
Drowning 4th	Drowning 1st	Self harm 2nd	Self Harm 8th	Self harm 12th
Falls 7th	Road traffic 4th	Road traffic 5th	Road traffic 14th	
Violence 9th	Falls 6th	Falls 10th		
	Self inflicted 13th			
	Fires 15th			

Table 2: Ranking of injury causes within the top 15 causes of burden of disease in China 1998

0-4 years	5-14 years	15-44 years	45-59 years	> 60 years
Drowning 4th	Drowning 1st	Self harm 1st	Self Harm 7th	Self harm 10th
Violence 8th	Road traffic 2nd	Road traffic 2nd	Road traffic 12th	Falls 15th
Road traffic 12th	Self Harm 6th	Drowning 9th		
Poisoning 14th	Poisoning 8th	Violence 10th		
	Violence 9th	Poisoning 13th		

Injury in Guangxi Province, China

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currents and bottom profiles constantly change.

- The long-term history of high drowning risk leads to fear of water and avoidance of learning to swim.
- Survival, rescue and resuscitation skills.
- There are few places to swim safely.

The Village of Hepu is determined to make a difference. They are seeking ways to teach people to swim and survive, to change the banks of natural rivers when other work is being done to provide better places to swim and to learn to swim. They are considering funding lifeguards at popular swimming spots and at the local school swimming pool that used to be closed over the hot summer vacation. There is a great opportunity for Australia to help them to develop their program.

Almost 70 people attended a week long workshop on injury prevention. They came from a wide range of backgrounds but mainly from regional and local health delivery and management. The workshop started with a quick overview of injury issues across the world and progressed through a modified application of Haddon to the local issues. Dr Jiatong Zhuo acted not only as language translator but cultural translator, changing the idiom to that of the local people. Later in the week presentations on motor vehicle injury were presented and discussed. The workshops were marked by increasing numbers and complexity of questions and an obvious interest in making a difference at the local level.

A lot more came out of this trip than a report to WHO. There will be action on the specific issues identified as starting points. Plans are under way for a delegation to visit Australia to look at injury prevention work. There should be a couple of good Guangxi papers at the Perth Conference and the chance for linkages into the wide world of injury prevention. And there will be continuing friendship with yet another group of people who are committed to making the world a safer place.

The original WHO brief focussed on the people of Guangxi learning from me. What actually occurred was mutual learning. I gained a clearer vision of how progress can be made with simple data and the commitment of people to make a difference in partnership.

Jerry Moller, who works as a private consultant, can be contacted on Tel: 08 8270 1004 or by E-mail: jmoller@senet.com.au

Merry Christmas

to all our readers, from the staff of the Research Centre for Injury Studies.

L to R: Renate Kreisfeld, Malinda Steenkamp, Yvonne Helps, Chris Wendt, Jill Carlson, Stacey Wendt, Steve Trickey, Ray Cripps, James Harrison, Lachlan Johnson

AUSTRALIAN INJURY PREVENTION NETWORK

Perth Conference Update

16-18 March 2003

If the number of abstracts is any indication, the next injury conference being held in Perth is set to be a winner. Twice the number of abstracts anticipated have been received. We report here on the latest arrangements for the conference.

Timetable:

Sunday 16 March

4.00 – 5.30 pm Opening Plenary I: Partnerships for the Future in Injury Prevention and Control
Speakers: Dr Etienne Krug, WHO; Hon Kay Patterson, Minister for Health, Australian Government*; Commissioner for Health, Department of Health, Western Australia*.

5.30 – 7.00pm Welcome reception

Monday 17 March

9.00 – 10.30am: Morning Plenary II Addressing the global burden of road traffic injuries
Speakers: Ms Rochelle Sobel, ASIRT; Prof Gopalakrishna Gururaj, India; Mr Tony Bliss, World Bank.

11.00–5.00pm: Five parallel sessions (workshops or proffered papers)
over three time periods (11.00 – 12.30pm, 1.30 –3.00pm, and 3.30–5.00pm).

3.30–5.00pm: Closing Plenary III
Speakers: Dr Margie Peden, WHO and others to be confirmed.

5.00 – 6.30pm: Social drinks

7.00pm onwards: Conference dinner

Tuesday 18 March

7.00 – 8.00am: AIPN breakfast and AGM

9.00–10.30am Plenary IIIA Assessing the burden of injuries
Speakers: Dr Le Cu Linh, Vietnam; Ms Delia Hendrie, Australia; Prof John Langley, New Zealand.

9.00-10.30 am: Plenary IIIB Suicide prevention: current issues and future directions
Speakers: Professor Sven Silburn, Australia; Dr Jemaima Tiatia, New Zealand*.

11.00–3.00pm: Five parallel sessions (workshops or proffered papers), over two time periods (11.00–12.30pm, 1.30–3.00pm).

Workshops sessions:
Drowning (Hosted by the Royal Life Saving Association);
Child injuries (Hosted by International Society for Child and Adolescent Injury Prevention and Kidsafe, WA);
Suicide (Hosted by the Ministerial Council for Suicide Prevention);
Road traffic injuries (Hosted by Global Forum for Health Research Road Traffic Injuries Network);
Social marketing.

Keynote speakers:

Professor Gopalakrishna Gururaj, Department of Epidemiology, National Institute of Mental Health and Neuro-sciences, India;
Ms Delia Hendrie, Injury Research Centre, The University of Western Australia;
Dr Etienne Krug, World Health Organization, Geneva, Switzerland;
Professor John Langley, Injury Prevention Research Unit, University of Otago Medical School, New Zealand;
Dr Le Cu Linh, Hanoi School of Public Health, Vietnam;
Professor Sven Silburn, Telethon Institute for Child Health Research, Perth,Western Australia;
Ms Rochelle Sobel, Association for Safe International Road Travel, Potomac, USA.

Other key international and prominent local speakers have also been invited to present at this conference.

Early bird registration:

Closes on 31st January 2003.

Further information:

Contact Katie Clarke, the Conference Manager, at Congress West Pty Ltd, PO Box 1248 West Perth WA 6872, Tel: + 61 8 9322 6662 or 9322 6906; Fax: + 61 8 9322 1734; Email: conwes@congresswest.com.au Website: www.congresswest.com.au/injury/

* *To be confirmed.*

Staff changes at RCIS

Malinda Steenkamp, whose name has regularly appeared in the Monitor, will leave RCIS at the end of the year to take up residence in the United States. Her decision stems from her husband's recent receipt of a 'green card' which will enable him to work in the US.

In the first instance, Malinda will take a leave of absence from the University.

Since her appointment several years ago she has endeared herself to her colleagues and become highly respected within the broader injury community. She will be most sorely missed.

Peter O'Connor has also left the employ of the Centre after having accepted a voluntary separation from the University.

Injury on the Internet

Babies on adult beds

A recent review of US Consumer Product Safety Commission data has revealed that 122 children under the age of 2 have died in incidents associated with features of adult beds over a three year period (1999-2001).

A total of 43 children died after they were entrapped—or seem to have been entrapped—mostly between the bed and a wall. 15 entrapments involved headboards, footboards or bed frames and 2 deaths occurred in which a child was found entrapped in between the bed and another object.

15 children died due to asphyxia from being face down or prone on the bed.

13 children died in incidents that were possibly related to bedding.

There were 12 fatalities related to falls from beds.

In addition there were 39 fatalities where the specific circumstances were unknown but where the deaths involved asphyxia on an adult bed.

The CPSC report appeared in the *Consumer Product Safety Review*, Vol 7, No 2, Fall 2002 which can be downloaded from the Internet: www.cpsc.gov/cpscpub/pubs/cpsr_nws26.pdf

New course:

Injury epidemiology, prevention and control

The Commonwealth Department of Health and Ageing through its Public Health Education and Research Program (PHERP) is funding the development of a one semester course in injury epidemiology, prevention and control. Flexible delivery is a key component of this innovative program and it will comprise a two-day face-to-face short course (held in three cities: Sydney, Brisbane and Perth) and a one semester online course. The course will have a practical focus and is being developed using expertise from around the country including The University of Western Australia (UWA), The University of Sydney, The University of Queensland, Monash University and Flinders University. Anyone with an interest in injury prevention issues is welcome to enrol. This includes health department staff, doctors, nurses, students of public health, researchers, managers and anyone working in areas such as child safety and road trauma prevention. Accreditation for completing the course will be available for students completing higher degrees in public health.

Short courses will run in 2003 and the online course will commence in 2004.

For further information, please contact Dr Suzanne Cordova at the Injury Research Centre (UWA) on 08 9380 7057 or by e-mail scordova@dph.uwa.edu.au

ICECI—latest developments

The International Classification of External Causes of Injury (ICECI) has been accepted into the WHO Family of International Classifications as the alpha version of a *Related Classification*. This was agreed by the annual meeting of the Heads of WHO Collaborating Centres for the Family of International Classifications at Brisbane, in October 2002, and is an important step in formalising the relationship between ICECI and the International Classification of Diseases.

Version 1.1 of ICECI was submitted for consideration. This version was the product of a taxonomic review and revision of version 1.0, undertaken by NISU in collaboration with the National Centre for Classification in Health.

Indexing and translation of the ICECI (initially into French) are in progress. Governance and update mechanisms are being put in place as the ICECI moves from development towards implementation.

For further information, contact James Harrison at RCIS, E-mail: james.harrison@nisu.flinders.edu.au Tel: 08 8374 0970. The ICECI submission is available on the Internet (WHO-FIC meeting paper number 74): www.aihw.gov.au/international/who_hoc/ The ICECI Website is www.iceci.org

Child Safety on Farms

One child dies every ten days on average due to farm-related incidents in Australia.

In response to this distressingly high statistic, Farmsafe Australia—a nationally representative farmer-led organisation—has developed a National Strategy for Child Safety on Farms. The Federal Department of Health and Ageing has provided three year funding to implement the strategy.

One of the first initiatives, announced at the launch of the national strategy in Canberra on 11 December 2002 by the Minister for Health and Ageing, Senator the Hon Kay Patterson, is a summer safety for children on farms campaign.

Program Leader of the Child Safety on Farms Strategy, Laurie Stiller, believes that while times are tough on the land, they don't need to be made any more difficult by unnecessary tragedy:

> "These tragedies can ruin marriages and destroy farm businesses. Farmers plan for the possibility of drought, hail and pests. How much more important is it to get your farm organised so that the kids are safe from serious injury or worse? It's one of those things that you just have to get on with."

At the heart of the campaign is a checklist that farmers with children or child visitors are encouraged to use to identify the key risks to children on their farms and to ensure that they are adequately controlled. This will be supported by a national competition to find the farms that have done the best job in identifying and controlling risks to children.

The checklist covers the risks responsible for the bulk of child injury and death on farms, namely:

- Drowning of children aged 0-5 years
- Injury associated with farm machinery - for both younger (0-9 yrs) and older children (10-15 yrs)
- Injury associated with 2 and 4 wheeled motorcycles for children aged 5-14 years
- Injury associated with other farm vehicles
- Horse related injury

The best way to control risk is by eliminating the risk, for example by filling in disused ditches. But clearly this is not always possible. The next best approach is to place a "hard barrier" between the child and the hazard, for example, by providing a safe and secure play area for toddlers such as a fenced house yard.

Case histories have shown however that even these barriers sometimes fail, so it is important to plan for that potential and have back-up measures in place including supervision, 'out of bounds' areas that are clearly communicated to the child and first aid skills (including mouth to mouth resuscitation) in the event of an incident occurring.

The checklist and details of the competition can be downloaded from the Farmsafe Australia website www.farmsafe.org.au or by contacting Farmsafe on Tel: 02 6752 8218.

For more information contact: Laurie Stiller at the Australian Centre for Agricultural Health and Safety, Tel: 02 6752 8218; E-mail: lauries@health.usyd.edu.au

STRATEGIC INJURY
PREVENTION PARTNERSHIP

Communique

3 October 2002

The 7th Meeting of the Strategic Injury Prevention Partnership was held in Adelaide on 3 October 2002. Members attending the meeting were Rod McClure (Chair), James Harrison (AIHW), Kerry Smith (Commonwealth & SIPP Secretariat), Richard Franklin (AIPN), Pam Albany (NSW), Michael Tilse (QLD), Nicole Bennett (WA), Ron Somers (SA), Nicola Rabot (VIC), Stan Bordeaux (TAS) and Justine Glover via teleconference (NT). Apologies were received from Anna Perkins (ACT), John Wunsch (Consumer Affairs), John Scott (Co-Chair). Cynthia Spurr from SA, also attended.

New Chairing Arrangements

This meeting was the first under the recently instituted new Chairing arrangements. The National Public Health Partnership has appointed co-chairs Dr John Scott from Queensland Health as the Partnership representative, and Associate Professor Rod McClure of the University of Queensland. Associate Professor McClure is Chief Executive Officer and Research Director of Injury Prevention and Control (Australia) Ltd and Associate Professor (epidemiology) and Director of the Injury Research Group in the School of Population Health. Associate Professor McClure takes the lead role in the co-chairing arrangements with Dr Scott assuming the Chair should any conflict of interest issues arise.

Updates from jurisdictions

Members provided updates on their recent work.

Western Australia:

Nicole Bennett reported that the Injury Prevention Unit was working collaboratively with key WA academic and non-government organisations working on injury. This includes cross agency work and interests and will result in a more strategic approach to injury in WA.

Tasmania:

Stan Bordeaux reported that there was an increased interest in injury following a recent restructure in the Department. The unit was working closely with Kidsafe on falls prevention and playground safety. He also reported that good progress was being made on the Falls Demonstration Project and projects were due to commence in 2003.

South Australia:

Ron Somers reported that in the four years from 1997 – 2000 the South Australian Trauma Registry has shown a 50% drop in the severity adjusted mortality rate. This decrease in the risk of death of patients attending SA major trauma services is very significant for injury policy and practices.

Commonwealth:

Kerry Smith reported that there was increased interest and involvement at Ministerial level in injury. Kerry also reported that work is progressing on the development of a National Aboriginal and Torres Strait Islander Injury Prevention Plan, with the Aboriginal and Torres Strait Islander Injury Prevention Action Council (ATSIIPAC) now having a full committee, and the project to map injury prevention activity underway.

New South Wales:

Pam Albany reported that under the work being undertaken by the Injury Risk Management Centre, permission has been received from the Privacy Commissioner and the NSW Health Ethics Committee to link Roads and Traffic Authority data and NSW Health data. There is also the possibility of linking further data sets, for example ski resort data.

Queensland:

Michael Tilse reported on the successful recent launch of Injury Prevention and Control (Australia) by the Commonwealth Minister for Health and Ageing, the Hon Senator Kay Patterson. Michael said that IPCA would provide an effective vehicle to address particular injury issues and programs in Queensland.

Victoria:

Nicola Rabot reported on the numerous activities being undertaken for the Victorian Community Safety Month from 15–21 October. She also reported on the project (funded through her Department) with the Victorian Coroners' Office on toddler drownings in dams. This work will be published in the near future.

Northern Territory:

Justine Glover reported that new laws for isolation and separation pool fencing for new swimming pools will come into effect in the NT on 1 January 2003. The government will provide some incentives for pool owners to comply. Existing pools do not have to comply until the property is sold.

Consumer Affairs Division of the Department of Treasury:

John Wunsch was unable to attend the meeting but sent a written report. He reported that a mandatory standard for bunk beds comes into effect on 1 November 2002. This standard requires that there be no gaps in the structure which can present a fall through and hanging hazard. It also requires that there be an absence of protrusions, and roll out protection on all four sides of the top bunk. A new mandatory standard for

Continued on page 10

STRATEGIC INJURY
PREVENTION PARTNERSHIP

Communique

Continued from page 9

babywalkers also comes into effect on 1 November 2002. This will require walkers to meet specified stability performance, a mechanism to help prevent falls down stairs and comprehensive warning labels.

Australian Injury Prevention Network:

Richard Franklin reported that AIPN is extremely busy in the organisation of the 6th National Conference to be held in Perth in March 2003. He also reported that planning is underway for the 7th National Conference which will be held in Mackay in Queensland in September 2004. The updated AIPN website will be up by early December. AIPN are also developing policies in order to respond to media requests on injury issues.

National Injury Surveillance Unit:

James Harrison reported that NISU had recently published a number of reports under their contract with AIHW and the Commonwealth Department of Health and Ageing. NISU's work program includes a status report on each of the four priority areas under the National Plan.

Workforce Issues

Members noted that a consortium based at the University of WA was being funded through the Commonwealth under the Public Health Eduction and Research Program (PHERP Innovations Round 2) for a project to increase the capacity of the injury prevention workforce. The project will develop and implement a distance-based injury prevention unit run by a consortium of Australian universities. The project follows on from the findings of a Commonwealth project to identify and classify the injury prevention workforce, and extends a project previously agreed to by SIPP. SIPP members gave in-principle agreement to support the project according to their capacity and SIPP members will form part of the project Reference Group.

Evaluating the National Plan

Members agreed on the formation of an Evaluation and Performance Indicator sub-committee to implement a strategy to evaluate the current Plan and provide a review of potential priority issues for the subsequent Plan.

Future projects

SIPP members identified the need to raise the profile of injury prevention in Australia. It will therefore be identifying and implementing strategies in the next few months in order to address this issue. SIPP is also having preliminary discussions on providing background issues papers on specific injuries for the use of Coroners in their investigations of injury-related deaths.

Future meetings

The next SIPP meeting will be by teleconference in January 2003. The next face-to-face meeting will be held on 16/17 March 2003 in conjunction with the 6th National Conference on Injury Prevention and Control in Perth WA. Members agreed that the face-to-face meetings would move around the jurisdictions and further agreed to investigate the use of video conferencing facilities.

More information

SIPP is a sub-committee of the National Public Health Partnership. To obtain more information on SIPP or the Partnership, see the SIPP web page at **www.nphp.gov.au/sipp/index.htm** or E-mail the SIPP Secretariat at kerry.smith@health.gov.au

Officially launched:

The National Coronial Information System

November saw the official launch of the National Coronial Information System (NCIS), the world's first electronic national database of coronial information. It has taken a lot of time and much effort by many people to get this system up and running and its arrival has been keenly awaited.

In future, access to NCIS will be available to authorised users via the Internet. It will require users to have an Internet Explorer browser, Version 5.0 or greater. Applications for access to the data are open to individuals or organisations with a role or interest in public health and safety (eg research and public sector agencies). A fee may be payable by users. All fees are levied on a cost recovery basis and will depend on the level of access sought.

The Monash University National Centre for Coronial Information (MUNCCI) which is developing and managing the system has a website which provides extensive information about the system. Applications to access NCIS data can be directed to ncisapplications@vifp.monash.edu.au or Tel: 03 9684 4323.

NSW Child Deaths 2001-2002

The latest report of the NSW Child Death Review Team appeared recently. We report here on some of the main findings.

Between July 2001 and June 2002, the deaths of 616 children aged 0–17 years were registered in NSW– accounting for a rate of 28.8 deaths per 100,000 children in that age group.

The highest rates of death were for infants under 12 months of age, mainly as the result of conditions which originated in the perinatal period.

After infancy, death rates dropped dramatically and remained quite low and stable. Between the ages of 15 and 17, however, deaths rose sharply as a result of transport accidents (29 deaths, 10.8 deaths per 100,000 population) and suicide (15 deaths, 5.6 deaths per 100,000 population).

Generally, the rates of death for male children was higher than that for females. An exception was a higher rate of female suicide in 1999.

45 children were identified as being Aboriginal or Torres Strait Islander (7.3% of child deaths in this period). The Indigenous child death rate was extremely high at 80.4 deaths per 100,000 Indigenous children compared to 37.3 per 100,000 non-Indigenous children 0–17 years.

Over the period of 1996-2001 there has been an overall decrease in the rate of transport fatalities. 50 children died in transport incidents, which was the most common external cause of death (3.1 deaths per 100,000 population 0–17 years). This included passengers (n=23), pedestrians (n=12), car drivers (n=7), pedal cyclists (n=4) and motor cyclists (n=1). Three deaths involved water transport incidents.

Males accounted for 78% of transport fatalities.

11 children died as the result of an assault in 6 separate incidents (5 of the 6 incidents occurred in a familial context with 3 of these incidents involving multiple fatalities).

20 children drowned during the period, the majority (60% aged under 5 years). 7 children drowned in private swimming pools, 5 in dams or ponds, 5 in bodies of natural water, 2 in bathtubs/spas and 1 in a public pool.

17 children aged 13–17 died as the result of suicide (12 males, 5 females). 12 of the 17 children died as the result of a hanging.

Less common causes of death included 7 children who were crushed by inanimate objects or exposure to inanimate forces. 3 children died from falls and 2 died in house fires.

The report also looks at coronial cases, and case reviews of abuse and neglect deaths.

The full report is available on the Internet: www.kids.nsw.gov.au/publications/cdrt2000.html#ar2001

Inquiries should be directed to the NSW Commission for Children and Young People, Tel: 02 9286 7276; E-mail: kidsk@kids.nsw.gov.au

ABORIGINAL AND TORRES STRAIT ISLANDER INJURY PREVENTION ACTION COUNCIL (ATSIIPAC)

ATSIIPAC has the task of developing a National Aboriginal and Torres Strait Islander Injury Prevention Plan in recognition of the extremely high rates of injury in Aboriginal and Torres Strait Islander communities.

Aboriginal and Torres Strait Islander Australians experience mortality and morbidity through injury at a much higher rate than do other Australians in the population. In 1998-2000, Indigenous injury death rates were about four and a half times the non-Indigenous rates for both males and females. Injury was the third leading cause of death amongst Indigenous Australians, resulting largely from motor vehicle crashes, fire, drowning, poisoning and violence.

Key Activities in 2001/2002

ATSIIPAC Committee

ATSIIPAC has had several vacancies over the past 18 months. However, the committee now has three new members with a representative recently appointed for ATSIC, a second NACCHO representative and a second Standing Committee of Aboriginal and Torres Strait Islander Health (SCATSIH) member being appointed. The Committee has been unable to identify a representative for the Torres Strait Islander people.

The Committee is yet to elect a new Chair to replace Mr Tim Agius following his resignation earlier this year, but will do so at its next meeting to be held in early December.

Injury Project

The Commonwealth has contracted the Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH) to undertake a project which will investigate and report on Indigenous injury prevention activities across Australia. This project will include a literature review, consultations with Indigenous communities and other people and organisations relevant to studying the incidence and prevention of injury in Indigenous communities.

This project is being conducted under the auspices of the National Public Health Partnership and ATSIIPAC. The CRCATH is coordinating the project on behalf of four organisations. The other organisations are the Yoorang Garang School of Indigenous Health, University of Sydney, Australian Indigenous Health *Infonet*, and New Directions in Health and Safety (Jerry Moller).

The project will inform policy development for the prevention of injury in Indigenous communities; provide evidence for strategic program development in Indigenous communities for the prevention of injuries; and assist in program development aimed at decreasing the rate and impact of injuries in Indigenous communities. It will provide the basis for consultations to be held in the first six months of 2003 on a draft National Aboriginal and Torres Strait Islander Injury Prevention Plan.

For more information contact Kerry Smith at the ATSIIPAC Secretariat, Injury Prevention Section, Commonwealth Department of Health and Ageing, Tel: 02 6289 8625; E-mail: kerry.smith@health.gov.au

In the Journals–recent Australian injury research

Alcohol and Other Drugs:

Daly JB, Campbell EM, Wiggers JH, Considine RJ. Prevalence of responsible hospitality policies in licensed premises that are associated with alcohol-related harm. *Drug Alcohol Rev* 2002; 21(2): 113-120.

Occupational Issues:

Lingard H. The effect of first aid training on Australian construction workers' occupational health and safety motivation and risk control behavior. *J Safety Res* 2002; 33(2): 209-230. Abstract at www.elsevier.com/inca/publications/store/6/7/9/index.htt

Suicide:

McLaren S, Hopes LM. Rural-urban differences in reasons for living. *Aust N Z J Psychiatry* 2002; 36(5): 688-692.

Toumbourou J, Gregg M. Impact of an empowerment-based parent education program on the reduction of youth suicide risk factors. *J Adolesc Health* 2002; 31(3): 277.

Joiner TE Jr., Jon J. Pfaff JJ, Acres JG. Characteristics of suicidal adolescents and young adults presenting to primary care with non-suicidal (indeed non-psychological) complaints. *Eur J Public Health* 2002; 12(3): 177-179.

Page A, Morrell S, Taylor R. Suicide and political regime in New South Wales and Australia during the 20th century. *J Epidemiol Community Health* 2002; 56(10): 766-772.

Page A, Morrell S, Taylor R. Suicide differentials in Australian males and females by various measures of socio-economic status, 1994-98. *Aust N Z J Public Health* 2002; 26(4): 318-324.

Eckersley R, Dear K. Cultural correlates of youth suicide. *Soc Sci Med* 2002; 55(11): 1891-1904. Abstract at www.sciencedirect.com/science/journals

Carter GL, Clover KA, Bryant JL, Whyte IM. Can the Edinburgh Risk of Repetition Scale predict repetition of deliberate self-poisoning in an Australian clinical setting? *Suicide Life Threat Behav* 2002; 32(3): 230-239.

Eye injuries:

Eime RM, Finch CF, Sherman CA, Garnham AP. Are squash players protecting their eyes? *Inj Prev* 2002; 8(3): 239-241. Full text at ip.bmjjournals.com/

Transport:

Keeffe JE, Jin CF, Weih LM, McCarty CA, Taylor HR. Vision impairment and older drivers: who's driving? *Br J Ophthalmol* 2002; 86(10): 1118-1121. Abstract at bjo.bmjjournals.com/

Tay R. Exploring the Effects of a Road Safety Advertising Campaign on the Perceptions and Intentions of the Target and Nontarget Audiences to Drink and Drive. *Traf Inj Prev* 2002; 3(3): 195-200.

O'Connor PJ, Kloeden C, McLean AJ. Do Full-Face Helmets Offer Greater Protection Against Cervical Spinal Cord Injury than Open-Face Helmets? *Traffic Inj Prev* 2002; 3(3): 247-250.

Lam LT. Distractions and the risk of car crash injury: the effect of drivers' age. *J Safety Res* 2002; 33(3): 411-419.

Cercarelli LR, Knuiman MW. Trends in road injury hospitalization rates for Aboriginal and non-Aboriginal people in Western Australia 1971-97. *Inj Prev* 2002; 8(3): 211-215. Full text at ip.bmjjournals.com/

Research Methods, Surveillance, and Codes:

McClure RJ, Peel N, Kassulke D, Neale R. Appropriate indicators for injury control? *Public Health* 2002; 116(5): 252-256. Abstract at www.nature.com/ph/journal/v116/n5/index.html

Holland A, Kirby R, Browne G, Ross F, Cass D. Penetrating injuries in children: Is there a message? *J Paediatr Child Health* 2002; 38(5):487-491.

Morrell S, Page A, Taylor R. Birth cohort effects in New South Wales suicide, 1865-1998. *Acta Psychiatr Scand* 2002; 106(5): 365-372.

Alcohol and Other Drugs:

Chikritzhs T, Stockwell T. The impact of later trading hours for Australian public houses (hotels) on levels of violence. *J Stud Alcohol* 2002; 63(5): 591-599.

Violence:

Hegarty KL, Bush R. Prevalence and associations of partner abuse in women attending general practice: a cross-sectional survey. *Aust N Z J Public Health* 2002 Oct;26(5):437-442.

Williams GF, Chaboyer WP, Schluter PJ.Assault-related admissions to hospital in Central Australia. *Med J Aust* 2002; 177(6): 300-304. Full text at www.mja.com.au/public/issues/contents.html

In preparing this list of citations, we acknowledge our use of the Internet resource, Safetylit, which is the work of the Center for Injury Prevention Policy & Practice at the San Diego State University (www.safetylit.org).

Elderly falls: NSW plans for increased service demand

Continued from page 4

rise in bed day demand for people aged 75 years or older (13,907 to 16,637 bed days) between 2001 and 2016 and a gradual, but smaller, rise in bed day demand for those aged between 60 and 74 years (6,709 to 9,315 bed days) during the same timeframe.

Of particular concern in the Central Sydney region is the Canterbury Statistical Local Area (SLA) where bed day demand for fall injury for those aged 60 to 74 years and those aged 75 years or older is double or greater than the bed day demand for these age groups in the other SLAs in the Central Sydney region.

Taking into account all age groups, total direct costs to the health system for fall-related injury in the Central Sydney region are estimated to increase from $23.519 million in 2001 to $27.053 million in 2016 – a growth of 13.1%.

The document describing the fall injury indicators, along with those for each of the Area Health Services, are available on the Internet: www.health.nsw.gov.au/public-health/health-promotion/improve/injuryprev/fallinjuryindicators/injuryindicators.html

New on the RCIS Website

Hospital separations due to injury and poisoning, Australia 1999–00.

www.nisu.flinders.edu.au

Injury prevention in Mongolia

Pam Albany
NSW Health Department

In August and September of this year I was fortunate to be invited to work for three weeks as a short-term consultant to the World Health Organization in Mongolia. The invitation pitchforked me into a world and conditions I had not experienced before, and caused me to grow a few new skills very rapidly.

Mongolia is a landlocked country bordered by Russia in the North and China in the South. It is quite poor with much foreign aid (and the relevant personnel) in the country. It is quite mountainous, dry and by now (November) it will be extremely cold. When I arrived at 4.30am in the morning in August it was a very hot 38 degrees!

The government of Mongolia had decided to establish a National Program for Injury Prevention involving all their relevant government agencies, and requested the World Health Organization provide a consultant to recommend a range of strategies, which might be employed. Another task required was the development of a national survey tool to identify the causes of injury. Everything is made more difficult in this sort of a role when few people speak English and the need for an interpreter is constant.

I examined the data sources already held in the country and discovered that Mongolia is quite data rich when it comes to injury. Mongolia has been collecting ICD-10 for inpatient and death data since 1996 and had in addition, pretty comprehensive emergency and ambulance data. So the task of a national survey turned into developing the specifications for reporting on the data stocks already held. I was grateful at the time to be assisted in this task by people at NISU and the NSW Injury Risk Management Research Centre.

Dr NansaLma Shagdar MD, who is the project officer for the National Injury Program of Mongolia

Mongolia was until 10 years ago owned by the Soviets for a period of 40 years, and so, while I didn't get to see the results of the injury causation study, it was clear that the majority of the injury problems in Ullanbataar at least were European and not Asian. Difficult weather and road conditions, some old Russian vehicles with little passenger protection, plenty of vodka and a general disrespect for the rights of pedestrians pretty well sums it up. There are also issues, which are very much Mongolian. The replacement of flued heating for open fires in the GERS (those temporary dome shaped houses used by the majority of the population) have been responsible for a significant number of fires and direct contact burns, together with the propensity for using small children as jockeys in long horse races have kept the trauma surgeons pretty busy.

Most days were spent at the trauma hospital or in meetings with other government and UN agencies. There were however, a few other opportunities to take in the sights. I visited museums and art galleries and attended a "cultural performance" by the country's top orchestra, dancers and singers who are trying to reclaim the original music of Mongolia. I visited a tourist GER camp, sat at the place of honour (where Madeline Albright and the British Royal Family have sat) and enjoyed yet another mutton meal. If you like mutton in your meals, Mongolia is the place to go. Unfortunately the vegetarians were not well catered for (I think that I only saw fruit once during my three week stay). There were long periods of report writing and a great deal of time spent on my own in a hotel room. The job of a short term consultant can be lonely at times.

I returned after three weeks for a debriefing at WHO headquarters in Manila and then on to Sydney. Would I do it again? Probably—but next time I will pack my husband!

Pam Albany can be contacted on Tel: 02 9391 9679 or by E-mail: palba@doh.health.nsw.gov.au

Towards an Australian Safe Communities Foundation

Paul Kells, Founder of the Safe Communities Foundation of Canada and Dr Bo Henricson from the WHO Safe Communities Collaborating Centre in Sweden recently visited Australia. Their visit has prompted individuals from across Australia, who currently contribute to and participate in Safe Communities and related programs, to assess support for and to develop a vision for an Australian Safe Communities Foundation (ASCF).

This group recognises all of those currently committed to Safe Communities as essential to the development of the ASCF.

This paper seeks to inform people and groups that there is substantial support for an ASCF and to seek their input, support and involvement in the venture.

Background

Safe Communities was born in Sweden in 1983 and has evolved to become a vibrant means of promoting safety and reducing injury in both developed and developing countries and across all sectors and settings. It is formally recognised by the World Health Organization with more than 70 communities accredited across the world.

In Canada, the Safe Communities Foundation has been formed to catalyse, nurture and support Canadian Safe Communities. Thirty Safe Communities

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Towards an Australian Safe Communities Foundation

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have business plans recognised by the Canadian Foundation and many are progressing toward World Health Organization accreditation as operational long-term programs. The Canadian Foundation is an independent body committed to supporting the development and progress of Safe Communities in Canada.

Safe Communities have been established in NSW, Victoria, South Australia, Western Australia, Queensland and New Zealand. There are currently twelve Australian and two New Zealand WHO accredited communities and a further eight communities in Australia in the process of development to WHO standards.

In addition, the values and approaches of safe communities are adopted in many different places in conjunction with other programs and projects.

Most Australian States have now reached a point where coordinated activities will increase the efficiency of existing Safe Communities and the burgeoning number of new safe community initiatives. NSW has progressed to the point of a feasibility study for support mechanisms for Safe Communities. The possibility of an Australian Safe Communities Foundation has been canvassed in this assessment.

This initiative seeks to bring together all of the key players to assist in the formulation of an ASCF that transcends state, sector, private and public boundaries, building on the strengths already in place in each state. The performance of the Canadian Foundation suggests that there is merit in a Foundation that is independent and has strong partnerships with all sectors of the community. Government has been a strong supporter of existing Safe Communities and in some States government support is growing. There is a need for a Foundation that has the advantage of independence and interaction with public, private and community sectors but which works in partnership with government to support the Safe Communities movement.

An ASCF will support the growth and development of this movement in a similar manner to Canada. ASCF will negotiate with business, community organisations and government in all Australian States and Territories and assess the potential for the partnership to include New Zealand.

The proposed basis for an Australian Safe Communities Foundation

The Australian Safe Communities Foundation (ASCF) is dedicated to making Australia the safest country in the world to live, learn, work and play, one community at a time.

The mission of the Australian Safe Communities Foundation (ASCF) is to help people come together in the community to create a sense of awareness, understanding, ownership, support and leadership to implement effective local programs to eliminate injuries and suffering and the potential for harm.

Role

The Australian Safe Communities Foundation will

- complement the activities of government, business and other organisations, reaching where others can not, by building new partnerships between all levels of the community and their services;
- help governments and business to do what they can do to reduce local hazards and promote safety;
- promote community safety as everybody's business—continually striving for better ways to coordinate and combine our policies, programs and local government activities;
- recognise that 'damage' created in one arena creates cost implications and burden for other sectors and therefore interrelated risks require inter-related solutions; and
- act as a focal point for seed funding of new Safe Communities, supporting active Safe Communities and encouraging national and international interchange about effective Safe Community strategies.

Action plan

The first step in moving the development of an ASCF forward will be to circulate this paper as widely as possible. It will be circulated to all the contacts we have been able to identify so far. Each of these is encouraged to further circulate the paper to their networks. This is likely to work best if personal contact is made with intended recipients and opportunity for discussion is provided.

We are seeking comment on the relevance and importance of an ASCF and on the vision, mission and role statements in this paper. We want suggestions about ways to involve all stakeholders and how to effectively link a national process to state and local processes. We are also asking individuals to provide us with contact details and their indication of support for the development of an ASCF.

Information provided in response to this paper will be used to develop strategies for making an ASCF a reality. It will feed into the process of seeking formal commitment among business, government and community. The membership of the promotion group will be continually developed to represent all states and sectors and a cross-section of fields of interest.

An indication of widespread support across all states, sectors and types of organisation will provide a strong basis for negotiating formal commitment to an operating foundation. A business plan that identifies potential sponsors and funders, spells out clearly the scope and objectives of the ASCF, and preferred governance models will be developed.

All of those who provide feedback on this paper will be regularly informed of progress.

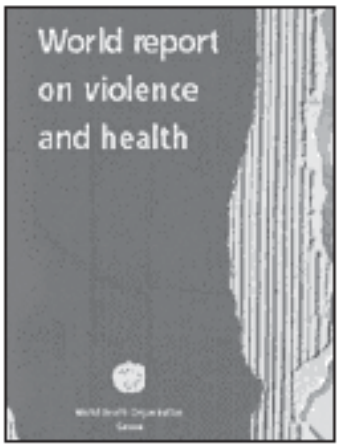
What you can do

Firstly, send comments on this paper to Kim Tolotta at ktolotta@workcover.com Kim is providing the contact point for feedback. Secondly, circulate the paper among people who are likely to be interested throughout your networks. Discuss it with them and encourage them to respond and pass it to their networks.

If you wish to be involved in or informed of future developments e-mail the following information to Kim. Organisational affiliation need only be supplied where your organisation wishes to identify its support for the ASCF. Your details will be added to a mailing-list for communication.

Something to read ...?

WHO Report on violence



This report, the subject of our cover story, is available on the Internet: www5.who.int/violence_injury_prevention/main.cfm?s=0009 where it can be downloaded in its complete form, chapter by chapter, or as a summary version. Separate fact sheets are also available at the site. Details about ordering printed copies are also available at the website.

When it's right in front of you

Sub-titled *Assisting health care workers to manage the effects of violence in rural and remote Australia*, this manual published by the National Health and Medical Research Council combines experience, consensus and available evidence to make suggestions about options for action. Copies of the report can be downloaded from the NHMRC Website: www.health.gov.au/nhmrc/publications/synopses/hp16syn.htm

Older Australia at a Glance

Information about this AIHW publication is contained in the item beginning on page 3.

As is the norm for AIHW publications, the full report is available on the Internet: www.aihw.gov.au/publications/index.cfm?type=list&id=2

Printed copies can be purchased for $20.00 from InfoAccess, 132 447 (tollfree anywhere within Australia), or +61 2 6293 8300.

Older Australia at a glance

Continued from page 3

was a total of 6,138,398 hospital separations. This gave rise to an all-ages rate of 318 hospital separations per 1,000 persons compared with 844 per 1,000 amongst those aged 65 and over.

Not only does frequency of hospitalisation increase with age, so too does the duration of the stay. In 2000-01, patients aged 65 and over accounted for 10.8 million patient days (48% of all patient days). Patients aged 65 and over stayed 5.3 days on average compared with 3.7 days across all age groups.

Principal diagnoses

Each hospital separation is accompanied by a principal diagnosis (ie the diagnosis that is deemed to be chiefly responsible for occasioning the admitted patient's episode of care in hospital). In 2000-01, the three most common principal diagnoses were cardiovascular disease (12.6%); cancer (10.6%) and digestive system disorders (10.4%). By comparison, a principal diagnosis of injury and poisoning accounted for 5.1% of hospital separations.

The two most common external causes of admission to hospital for older people were complications of medical and surgical care (116,900 separations) and falls (80,300 separations).

Living arrangements/housing

The report also looks at a wide range of other aspects of being an older Australian such as the social context (eg leisure and lifestyle, income sources) and the circumstances of special groups (eg Indigenous people or those in rural and remote communities), the Australian health and welfare system and the aged care system.

For details about obtaining copies of the report, see *Something to Read* above.

Editor's Note

The *Injury Issues Monitor* is the journal of the Research Centre for Injury Studies at the Flinders University of South Australia.

Letters to the Editor are welcome.
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Diary

Note: where available, Internet addresses have been provided below for conference websites. For those meetings that don't have their own website, detailed descriptions of the events are normally available at our website: www.nisu.flinders.edu.au/events/

3rd International Course on the Global Burden of Injury
27-31January 2003
Stockholm, Sweden
Contact: Karen Leander,
Tel: +46 8 517 77924; Fax: +46 8 517 7930;
E-Mail: karen.leander@smd.sll.se
Website: www.phs.ki.se/worldhealth/

Short course: The Analysis of Linked Health Data: Principles and Hands-On Applications
17-21 February 2003
Canberra
Course offered by the National Centre for Epidemiology and Population Health and taught by Professor D'Arcy Holman
Contact: Heather McIntyre,
Tel: 02 6125 5621; Fax: 02 6125 0740;
E-Mail: heather.mcintyre@anu.edu.au

International Conference on Managing Fatigue in Transportation
9-13 March 2003
Perth
Contact: Laurence Hartley, Institute for Research in Safety & Transport,
Tel: +61 8 9360 2398; Fax: +61 8 9360 6492;
E-Mail: hartley@socs.murdoch.edu.au
Website: www.congresswest.com.au/fatigue2003

1st Asia-Pacific Injury Prevention Conference AND 6th National Conference on Injury Prevention and Control
16-18 March 2003
Perth
Contact: Congress West Pty Ltd,
Tel: +61 8 9322 6662 / +61 8 9322 6906;
Fax: +61 8 9322 1734;
E-Mail: conwes@congresswest.com.au
Website: www.congresswest.com.au/injury

12th International Conference on Safe Communities
18-20 March 2003
Hong Kong, China
Contact: Conference Agent,
Tel: +852 2968 0222; Fax: +852 2590 0099;
E-Mail: safety2003@oshc.org.hk
Website: www.safety2003.org.hk

Injury Researchers' Meeting
19-21 March 2003
Perth
Contact: Congress West,
Tel: +61 8 9322 6662 Fax: +61 8 9322 1734;
E-Mail: conwes@congresswest.com.au

PHAA Incarceration Conference
2-3 April 2003
Brisbane
Contact: PHAA Secretariat, Tel: 02 6285 2373;
E-Mail: conference@phaa.net.au

A learning journey: integrating the safety community model in large urban centres
2-4 April 2003
Calgary, Alberta, Canada
Contact: Greg Steinraths, Tel: +403 268 1159;
E-Mail: gregory.steinraths@gov.calgary.ab.ca

Safety in Action 2003
8-10 April 2003
Melbourne
Contact: Conference Organiser,
Tel: +61 3 9654 7773; Fax: +61 3 9654 5596;
E-Mail: safety@aec.net.au Website: www.aec.net.au

4th European Convention in Safety Promotion and Injury Control
10-11 April 2003
Paris, France
Contact: Congress Secretariat,
Tel: +31 22 0511 4500; Fax: +31 20 5114 510;
E-mail: ecosa@consafe.nl
Website: www.ecosa.org

18th International Technical Conference on the Enhanced Safety of Vehicles
19-22 May 2003
Nagoya, Japan
Contact: Conference Secretariat,
Tel: +81 3 3234 4704; Fax: +81 3 3234 4456;
E-mail: esv2003@procom-i.co.jp
Website: www.esv2003.com/

11th Annual Scientific Meeting of the Australasian Faculty of Rehabilitation Medicine
23-26 May 2003
Hobart
Contact: DC Conferences Pty Ltd,
Tel: 02 9954 4400; Fax: 02 9954 0666
E-mail: afrm@dcconferences.com.au
Website: www.dcconferences.com.au/afrm.html

2nd International Safe Community Conference on Cost Calculation and Cost-effectiveness in Injury Prevention and Safety Promotion
10-13 June 2003
Falun, Dalarna, Sweden
Contact: Safe Community Conference 2003,
Tel: +46 23 83 641; Fax: +46 23 83 314;
E-mail: safe2003@falun.se
Website: www.falun.se/safe2003/

5th Nordic Safe Community Conference
26-29 August 2003
Helsinki, Finland
Contact: Merja Soderholm,
Tel: +358 9 1607 4028;
E-mail: merja.soderholm@stm.vn.fi
Website: www.safe2003.net

XXII Congress of the International Association for Suicide Prevention (IASP)
10-14 September 2003
Stockholm, Sweden
Deadline for abstracts: 15 March 2003.
Contact: Congress Secretariat,
Tel: +46 8 5465 15 99; Fax: +46 8 5465 15 99;
E-mail: iasp2003@stocon.se
Website: www.ki.se/suicid/iasp2003

1st International Congress on Health and Safety in Transport
16-18 September 2003
Paris, France
Contact: Riv Turquoise,
Tel: +(33) 01 47 95 54 54;
Fax: +(33) 01 47 95 54 55
E-mail: riv.turquoise@wanadoo.fr

35th Public Health Association of Australia Annual Conference
28 September to 1 October 2003
Brisbane
Deadline for abstracts: 1 April 2003.
Contact: PHAA, Tel: 02 6285 2373;
E-Mail: conference@phaa.net.au

Injury Prevention Network of Aotearoa New Zealand Conference
29-31 October 2003
Wellington, New Zealand
Contact: Valerie Norton, National Coordinator, IPNANZ, Tel: +64 4 472 2562;
E-mail: v.norton@ipn.org.nz
Website: www.ipn.org.nz

7th World Conference on Injury Prevention and Safety Promotion
6-9 June 2004
Vienna, Austria
Deadline for abstracts: 30 September 2003.
Contact: Fax: +43 1 715 66 44 30;
E-Mail: safety2004@sicherleben.at
Website: www.safety2004.info

References

1 Mathers C and Penm R. *Health system costs for injury and Poisoning and Musculo-skeletal disorders in Australia for 1993-94*. Health and Welfare Expenditure Series No. 6. AIHW Canberra. 1999.

2 World Health Organization. *Injury: A Leading Cause of the Global Burden of Disease*. WHO Geneva. 1999. Tables 39 and 40.