INJURY ISSUES MONITOR

## In this issue ...



# Alcohol and water safety

The Injury conference held in Perth during March provided an opportunity to launch a new report on alcohol and water safety. The report was the result of a project commissioned by the Commonwealth Department of Health and Ageing and was undertaken by James Harrison and Malinda Steenkamp of RCIS in conjunction with Tim Driscoll, a freelance injury consultant resident in New South Wales.

The report was prepared in response to an invitation to examine the role of alcohol in drowning and other types of injury associated with recreational aquatic activities. Its purpose is to collate available information, including new sources, to support priority setting and policy formulation.

The most significant findings of the report stemmed from a review of the literature and from an analysis of data from the National Coronial Information System.

### Literature review

As part of the project, a review of published literature was undertaken to assess the role of alcohol in drowning associated with recreational aquatic activity using published literature.

This resulted in the following findings:

- Alcohol is widely used in association with recreational aquatic activity in the United States, but there is little information regarding the extent of use elsewhere.
- *A priori* and anecdotal evidence suggests that alcohol is an important risk factor for drowning associated with recreational aquatic activity.
- The extent of increased risk associated with alcohol use, and the attributable risk due to alcohol use, are not well characterised.
- Drowning appears to be the most common serious water-related injury associated with alcohol.

*Continued on page 2*

# Reflections on the Perth Conference

**Mark Stevenson**

Chair, Conference Organising Committee for the
1st Asia-Pacific Injury Prevention Conference & 6th National Conference on Injury Prevention and Control

The 6th national injury conference and 1st Asia-Pacific Injury Prevention Conference is now behind us and it's time to reflect on the event.

With many people contributing numerous hours in the lead up to the conference, the resounding success of the conference was all the more satisfying. Particularly since we also hosted the 1st Asia-Pacific Conference which added further complexities to the already complex logistics of hosting a conference!

The size of the turn up was very pleasing—in fact over 300 delegates registered for the conference. Delegates from throughout Asia, as well as New Zealand and the US attended. There is no doubt that the Asia-Pacific focus of the conference will quickly become established as the key forum for injury researchers and practitioners from the region.

The quality of the papers, both oral and poster presentations, was excellent and we were delighted to have the support of large international agencies such as WHO, UNICEF and the World Bank. Several round table discussions and workshops were also included in the program. One of these provided an opportunity for a lively exchange of information about injury prevention in various countries namely, Vietnam, Bangladesh, China, Indonesia, Malaysia, the Philippines and Thailand. The success of this workshop bodes well for the establishment of links within the broader regional injury community and I expect that information sharing and other collaborations will follow.

Finally, I take this opportunity to extend my thanks to all those who participated in making this such a successful event.

**Mark Stevenson is the Director of the Injury Research Centre at the University of Western Australia. He can be contacted on Tel: +61 8 9380 1302 or E-mail: marks@dph.uwa.edu.au**

# Alcohol and water safety

Continued from page 1

- Alcohol is detected in the blood of about 30% to 50% of persons who drown whilst involved in recreational aquatic activity.
- The few relevant studies on the degree of increased risk suggest that persons with a blood alcohol level of 0.10g/100ml have about 10 times the risk of death associated with recreational boating compared with persons who have not been drinking. However, even small amounts of alcohol can increase risk.
- The population attributable risk seems to be in the range of about 10% to 30%.

As a result of the literature review, the authors concluded that alcohol is a significant causal factor in drowning associated with recreational aquatic activity. However, there are many areas for which more information is required if appropriate prevention activities are to be planned, initiated and evaluated.

The authors further concluded that, from an Australian perspective, the main areas where further work is needed appear to be:

- determining the extent of alcohol use in Australia in relation to recreational aquatic activity;
- obtaining information on the knowledge, attitudes and behaviours of Australians in relation to alcohol use and aquatic activity;
- determining the extent of increased risk of serious and fatal injury in association with recreational aquatic activity in Australia; and
- evaluation of current and proposed interventions to reduce the contribution of alcohol to serious and fatal recreational aquatic activity.

### Analysis of National Coronial Data

The analysis of National Coroners Information System (NCIS) data on the involvement of alcohol in drowning deaths and deaths associated with recreational boating (whether by drowning or not) represents one of the first uses of the NCIS as an information source on a significant public health issue. The aim was (1) to determine how useful the NCIS is as a source of information on drowning and the possible contributory role of alcohol, and (2) to describe what available information revealed about drowning and the role of alcohol. The primary interest was all drowning deaths, but there was also a focus on deaths associated with recreational aquatic activity.

The resultant chapter in the report describes the structure of the NCIS and the methods used to select and report on relevant NCIS deaths occurring between 1 July 2000 and 30 June 2001. It also reports on the difference between *Open* and *Closed* cases, as this has a bearing on data availability. The main findings were:

- A total of 282 drowning deaths were identified for the period investigated, of which 170 cases were closed. Another nine non-drowning deaths related to recreational aquatic activity were identified. Nearly 80% of the deaths occurred in males and the average age was about 42 years. About 50% of all drowning deaths were related to recreational aquatic activity.
- Alcohol appeared to contribute to about 21% of drowning deaths, and perhaps 30% of drowning deaths related to recreational aquatic activity.
- The NCIS appears to already provide very useful, and in some places comprehensive, information, but still has significant shortcomings in terms of the completeness and detail of information on many cases. The availability and quality of data also varies considerably between jurisdictions.

**Any enquiries about this study should be directed to James Harrison at RCIS, Tel: 08 8374 0970, E-mail: james.harrison@flinders.edu.au The full report is available on the RCIS Website: www.nisu.flinders.edu.au**

# Injury in the Asia-Pacific Region

To commemorate the occasion of the first Asia-Pacific Conference on Injury Prevention and Control held in Perth in March, we are including, in this issue of the *Monitor,* a small selection of papers about injury and its prevention in countries from the region.* Specifically, we're including an article by Dr Morten Giersing of UNICEF. He is sharing with us the early results of a national survey conducted in Bangladesh in order to assess the burden that injury is placing on that country. Bangladesh is also the focus of a report by Steven Parker of the Noarlunga Safe Communities program. A project on a much smaller scale than the survey, Steven's report describes a small, community based initiative in the Sherpur district which aimed to provide the local workers with eye protection.

Two other reports focus on the issue of suicide. Professor Gururaj of the National Institute of Mental Health and Neurosciences in India reports on a case control study he undertook with his colleagues to identify and examine risk factors for completed suicides in Bangalore. Jemaima Tiatia, a Samoan resident in New Zealand, has provided us with the results of her largely qualitative study of young Samoans who have attempted suicide in New Zealand.

Finally, we are reprinting an article prepared by UNICEF in Vietnam which looks at the problem of injury in that country and the steps that are being taken to counter the problem. This article is included in lieu of an excellent presentation at the Conference by Dr Le Cu Linh of the Hanoi School of Public Health, which could not, at this time, be reproduced for copyright reasons associated with its submission to a journal.

We will endeavour to include, in future editions of the *Monitor*, further reports on injury prevention in other countries of the Region. The *Monitor* has previously carried articles on Injury Prevention in Thailand (*Monitor 22*); and in China and Mongolia (*Monitor 26*).

* *Most of the articles included in this edition are limited to excerpts from the papers that were supplied to us.*

# Happy Snaps

## Taken at the Conference Dinner in Perth

*Richard Franklin, Royal Life Saving Society Australia and Lesley Day, Monash University Accident Research Centre*

*Deb Cutting, Chantelle Jeffrey and Linda Parsons, Health Department of Western Australia's Injury Prevention Program*

*Garry Waller, National Centre for Classification in Health and Philip Schluter, University of Queensland*

*Jerry Moller, New Directions in Health and Jenny Blitvitch, University of Ballarat*

*Jemaima Tiatia, Laura Mariu, and Betty Sio*

*Ngo Kieu Lan, Hoang Tuyet Mai and Nguyen Thuy Hong, all from UNICEF in Hanoi, Vietnam*

# Happy Snaps

**Taken at the Conference Dinner in Perth**

*Professor Otgon, National Trauma and Orthopaedic Centre in Mongolia, Isabel Sevede-Barden, Childhood Injury Prevention, UNICEF, Bui Huynh Long, Vietnam, Quynh Nguyen Thuy, Vietnam.*

*Kerryn Mulvenna, MUNCCI, and Lyndal Bugeja, Victorian State Coroner's Office*

*Tsharni Zazryn and Andrea Fradkin, Monash*

## New on the RCIS Website

O'Connor P. *Spinal Cord Injury 2000-01.*

Driscoll T, Steenkamp M, Harrison J. *Alcohol and Water Safety: National Alcohol Strategy 2001 to 2003-04.*

AIHW

## New Aboriginal and Torres Strait Islander Health Unit

The Australian Institute of Health and Welfare has very recently established a new Aboriginal and Torres Strait Islander Health and Welfare Unit. The Unit is located in the AIHW Resources Division in Canberra.

The Unit will deal with the full range of Indigenous issues, and will work to improve knowledge and statistics relating to the Indigenous population across the breadth of the AIHW work program.

The National Injury Surveillance Unit looks forward to collaboration with the Aboriginal and Torres Strait Islander Health and Welfare Unit.

Inquiries about the new Unit can be directed to Fadwa Al Yaman, at the AIHW, Tel: 02 6244 1146; Fax: 02 6244 1199; E-mail: fadwa.al-yaman@aihw.gov.au

# Assessing the burden of injury in Bangladesh

**Morten Giersing**
United Nations Children Fund (UNICEF) Bangladesh

Bangladesh, once recognised as the diarrhoeal disease capital of the world, and the home of ICDDR,B (International Centre for Diarrhoeal Diseases Research, Bangladesh), where ORS was pioneered, has made significant progress in improving child health in the last few decades. Mortality among under five year olds declined from 152 deaths per 1000 live births (BDHS 1989-90) to 94 deaths per 1,000 live births (BDHS 1999-2000)[1].

The surveillance of child mortality in Matlab (the study area of ICDDR,B) clearly shows both the phenomenal decline in under-five mortality (over 60%) and the cause of the decline over the last three decades. Infectious diseases like diarrhoea, acute respiratory infections, tetanus and malaria were targeted by vertical programs and have dropped dramatically since the 1980s. The hidden burden of injury related mortality now comes into focus: the proportional increase in deaths in Matlab attributable to drowning rose from 9% in 1983 to 53% in 2000[2]. The decline in diseases like diphtheria, whooping cough, tetanus and polio targeted by the Expanded Program on Immunisation (EPI) is a testimony to the efficacy of the EPI program.

The burden of child injury in developing countries is not new. But the proportion and the numbers are only now beginning to be recognised. Traditionally, the health information systems greatly underreport injury related mortality: the drowned child never makes it to the health facility, and the death is rarely registered in other ways in a poor country.

Moreover, injury death is often perceived as 'destiny' and a natural, unavoidable phenomenon.

Clinicians, epidemiologists, and program staff will also traditionally recognise only a certain spectrum of the causes of child death. As our understanding of the aetiologies improves, it now leads us to the question that if a child dies of pneumonia, why did the pneumonia occur? Was it a primary pneumonia, which is not connected with any other adverse health event, or was it, for example, the result of a near drowning that the child suffered the previous week? The normal health information system does not provide the answer as the hospitals and clinics do not track the antecedent cause of the pneumonia.

With this understanding, a nation-wide community based survey has been initiated by UNICEF-Bangladesh teamed with the Institute of Child and Mother Health (ICMH), and with technical assistance from The Alliance for Safe Children (TASC) and the Centers for Disease Control (CDC) in order to examine the morbidity and mortality pattern among all age groups from infancy to the elderly. The survey goes in detail to look at why and how the fatal and non-fatal injuries have occurred and the consequences of those injuries. This large national survey has other research nested in it: there are case-control studies to identify risk factors for high prevalence injuries such as drowning, there are behavioural and other qualitative studies to help understand and develop prevention programs. The capture-recapture method of the study would give an idea about the injury reporting system while the hospital based data would allow to demonstrate the direct costs of severe and fatal injuries.

110,000 rural households and 40,000 urban households are being surveyed, covering approximately 750,000 population. Recently, 19% (more than 21,000 households) of the rural sample was analysed. The result of the rural and urban components would be available by June 2003. A separate Dhaka 'mega-city' study would start in June. The data available will inform UNICEF Bangladesh's Country Program and allow the Government of Bangladesh and other partners to take appropriate steps for prevention and control of the prevalent causes of child injuries.

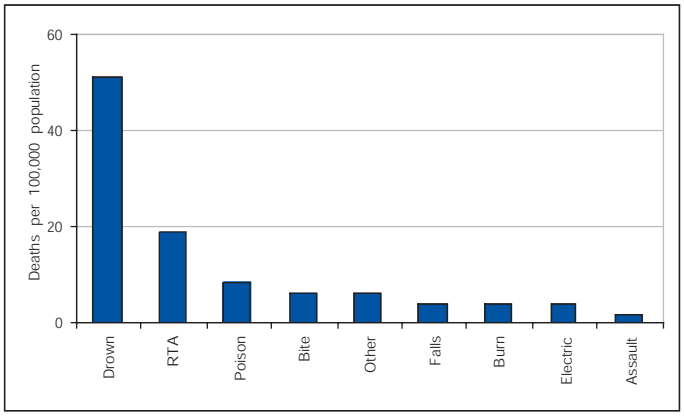
### *Preliminary results*

The early results of the Survey clearly show that injury has become a significant cause of death in all child age groups, with it being the second leading cause in children aged 1-4, and the leading cause in all children older than that. The same data for nonfatal illness and injury show that, with the exception of infants, injury is the leading cause of morbidity in each age group.

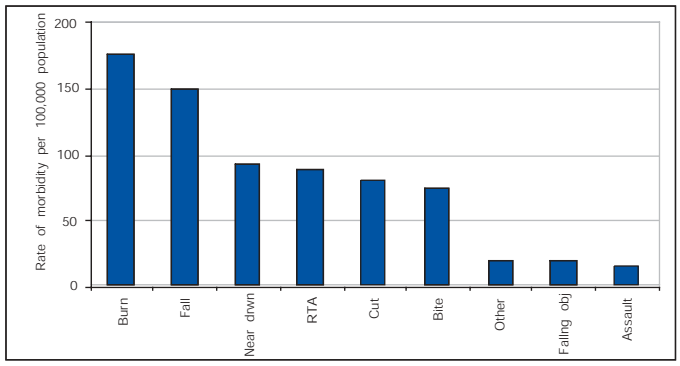
Drowning is the single biggest killer of children over 12 months. Injury accounts for 43% of child mortality in the age group 1-19 years of age. Road traffic accidents become the leading cause in adolescence and young adulthood, the pattern similar to the Vietnam survey. This pattern has also been observed in several rapid assessments by TASC in other countries in the East Asian and Pacific region (Thailand, Philippines). There is a very clear message for UNICEF's child mortality prevention programs—drowning is far and away the major killer of children from early childhood through early adolescence, and it should be a focus of our prevention programs.

Graph 1 shows the rates for fatal injuries. It is evident that drowning far outstrips all other causes of injury death.

Graph 2 shows the rates for different types of non-fatal child injury. Burns, falls, bites, cuts, near drowning and road traffic




*Graph 1: Rates of injury death by cause*




*Graph 2: Rates of non-fatal injury by cause*

*Continued on page 6*

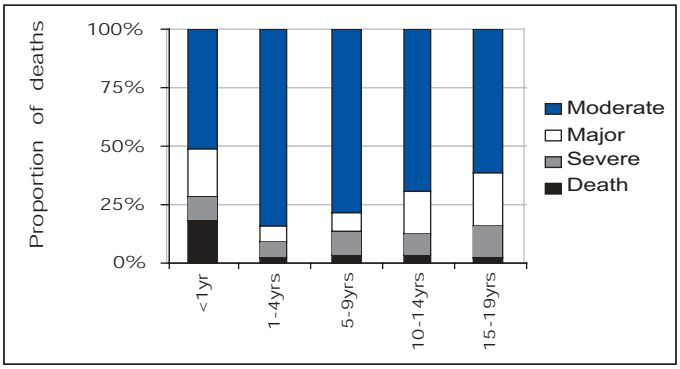
# Assessing the burden of injury in Bangladesh

**Continued from page 5**

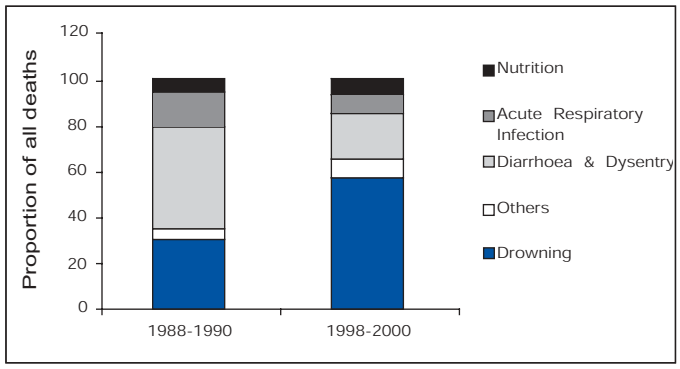
accidents are all significant causes.

As shown by Graph 3, the real burden of child injury lies in its morbidity. Most cases of reported injury were of moderate type (the person had sought medical care and incurred a loss of three days of school or work). Major types of injuries (requiring surgery or hospitalisation of 10 days) were the next most common group but severe types of injuries leading to permanent disability are also common.

The data represented in Graph 4 are almost an exact replica of the data derived from an earlier survey done in Vietnam. However, these data also differ markedly from the conventional wisdom that holds that infectious causes of mortality and morbidity far outstrip others in the child age groups in Bangladesh. Therefore, it is helpful to look for validation from other community acquired data to add confidence to the findings that will be startling to many. The columns of the graph represent child mortality (in Matlab) for two separate periods 10 years apart. They show the decrease in infectious causes (diarrhoea, dysentery and acute respiratory infections) and the increase in the proportion of drowning deaths. They also illustrate that the epidemiological transition for children most likely occurred late in the decade of the 1980s and early in the decade of the 1990s. In conclusion, the early survey results clearly show that injury has become a significant cause of death in all child age groups, with it being the second leading cause in children aged 1-4 years, and the leading cause in all children older than that.




*Graph 3: Severity of reported injuries*




*Graph 4: Changing pattern of mortality in Bangladesh*

*Drowning is the major cause of child mortality in Bangladesh*

The children in the photo look suspiciously like Vietnamese children; but the environmental drowning hazards are universal throughout Asia. We look forward to developing comprehensive child injury prevention programs that are integrated into all the other child health activities, and to share them with other countries in the region. And we hope that Bangladesh may soon again become a pioneer in child survival initiatives through its injury prevention and control programs.

**Morten Giersing can be contacted at UNICEF Bangladesh, Tel: +880 2 933 58 02, Fax +880 2 933 56 42, E-mail: mgiersing@unicef.org**

# World Health Day 2004

Planning has commenced for the World Health Organization's annual event held to mark the day of the establishment of the Organization. Traditionally the day is held on 7 April.

Road Safety has been selected as the theme for World Health Day 2004. The objectives for the day are:

- To raise awareness about the health impact and social and economic costs of road traffic injuries.
- To stimulate debate on the possibility for road traffic injury prevention.
- To issue a call for action.

Events will be organised around the world by governments, organisations and groups and the day will mark the start of a global campaign for road traffic injury prevention.

## World report on road traffic injury prevention

This report will be launched on World Health Day. It is the first major report on the topic issued by WHO in collaboration with the World Bank. The Report's main message is that road traffic injuries are a major but neglected public health problem requiring concerted multisectoral efforts for effective and sustainable prevention. It has five chapters covering fundamental concepts; global burden and intensity and impact of road traffic injuries; key determinants; intervention strategies; and conclusions and recommendations.

WHO invites and encourages as many people, institutions and organisations as possible to organise events to mark the day.

**For further details, contact the Department of Injuries and Violence Prevention at the WHO, Tel: +41 22 791 2881; Fax: +41 22 791 4332, E-mail: traffic@who.int Website:** www.who.int/violence_injury_prevention/

# Case study of risk factors for completed suicides in Bangalore, India

**Gururaj Gopalakrishna**
Departments of Epidemiology & Psychiatry
National Institute of Mental Health & Neurosciences
Bangalore, India

## Suicide trends 1989-2000

The rates for completed suicides in Bangalore have risen over time, from just over 20 per 100,000 population in 1989 to 35 per 100,000 during 2000.

## Incidence of attempted suicides

During 1999, a total of 1900 individuals completed suicides and it was estimated that nearly 15,000 and 19,000 attempted suicides. This equates to an incidence of 35 per 100,000 people for completed suicides and 200 and 325 per 100,000 for attempted suicides per year. The ratio of completed to attempted suicides is estimated to be somewhere in the range 1:7 to 1:10.

## Burden of suicide

Figure 1 uses a number of different data sources to estimate the burden of suicide in Bangalore. One can only guess at the number of people at risk as measured by having had suicidal ideas.

## Risk factors in completed suicides

A previous study undertaken in Chennai by Vijayakumar *et al.*[3] identified a series of risk factors for completed suicides. In decreasing order, these were:

Life events in the last month (28.50)
Axis 1 Disorder (19.50)
Family history of psychopathology (12.75)
Marital status (12.00)
Personality disorder (9.50)
Early death of parents (5.75)
Previous suicide attempt (5.20)
(The numbers in brackets are matched odds ratios).

## Case control study—objectives and methodology

The study's objectives were to:

*Continued on page 8*

# AUSTRALIAN INJURY PREVENTION NETWORK

## Glittering Prizes

The Conference Dinner in Perth was the occasion for the presentation of the AIPN's annual awards for excellence. Awards were given to the following people:

The AIPN Award for Contribution to Practice was given to Dale Hanson of the Mackay Health Service.

The Award for Contribution to Research went to Lesley Day of Monash University's Accident Research Centre.

A Special Award for Sustained Achievement was presented to our own James Harrison.

*L to R: Lesley Day, Shauna Sherker and Wendy Watson, MUARC*

Several awards were presented for outstanding papers at the Conference. These went to Nadine Levick for the best oral presentation, "Ambulance transport safety and crashworthiness: International advances addressing hazards and risk in the EMS environment". The Best Poster was prepared by Jenny Blitvich, Keith McElroy and Brian Blanksby for their presentation "The role of skill in the prevention of shallow water diving spinal cord injury". The award for the Best Student Paper was given to Shauna Sherker and Joan Ozanne-Smith "Are current playground safety standards adequate for preventing arm fractures?"

In recognition of the 1st Asia-Pacific Conference, an award was presented to Gururaj Gopalakrishna and his colleagues for "Risk factors for completed suicides in Bangalore: a case control study" (see the above article).

Student bursaries were given to Rebecca Dennis, Helen Myers and Wendy Watson.

## Stop the War

The Conference Dinner also provided an opportunity for the AIPN to collect the funds necessary to finance the placement, in the national media, of an advertisement on behalf of the Network, opposing Australia's decision to deploy troops as part of the 'Coalition of the Willing'.

**The AIPN's President, Richard Franklin, can be contacted on Tel: 02 9181 5444, extension 28, E-mail: rfranklin@rlssa.org.au**

# Case study of risk factors for completed suicides in Bangalore, India

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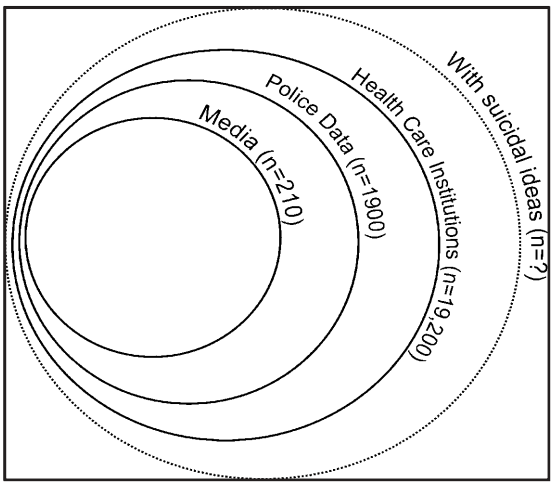



**Figure 1: Data sources used**

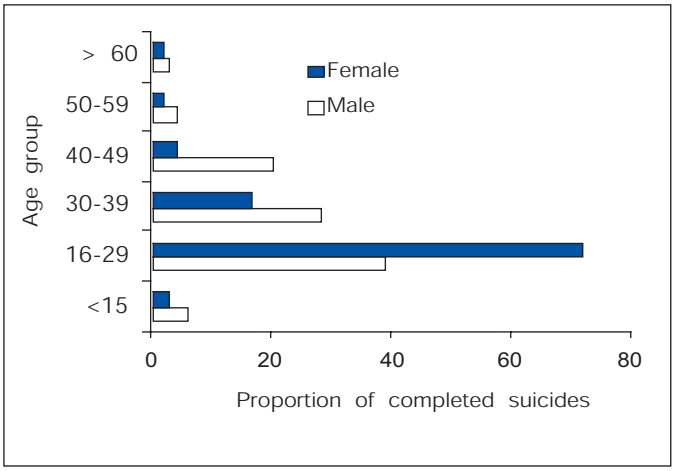



**Figure 2: Age and sex of completed suicides**

- identify risk factors for completed and attempted suicides in Bangalore;
- understand the role of social, economic, health, mental health, environmental and cultural factors in causation of suicides;
- prioritise risk factors for interventions.

The methodology used was a case control study and was undertaken during the period July 2001 to February 2002 in the city of Bangalore.

Details of completed suicides were obtained from the police department. The cases included were all suicides that had taken place during the past 6 months. The control group comprised people from the neighbourhood matched for age and sex. There were 269 cases and 269 controls. The study used trained research staff who conducted semi-structured interviews made up of 14 separate sections. A psychological autopsy method was used.

The information collected comprised identification details, socio-demographic characteristics, previous suicide attempts, life events, health (mental health) details, alcohol habits, social role, help seeking behaviour, social support, positive protective factors. Established standardised methods of data collection were used.

## Case control study—results

### *Age and sex distribution of completed suicides*

As is evident from Figure 2, males aged 16-29 are by far the most likely to die as a result of suicide.

### *Methods of suicide*

As can be seen in Figure 3, hanging was by far the most commonly chosen means of suicide for both males and females.

### *Risk factors*

The major social risk factors identified by the study were Social Problems (OR 5.96); the Nuclear Family (OR 0.62); Extended Family (OR 1.51).

Economic risk factors were Bankruptcy (OR 7.10); Poverty (OR 2.93); and Financial Problems (OR 1.61).

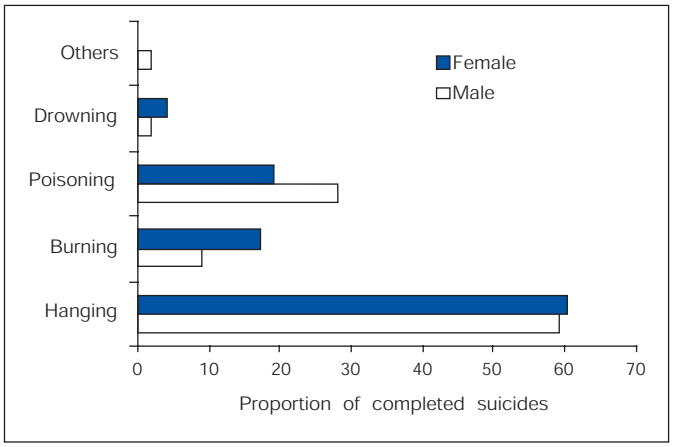



**Figure 3: Methods of suicide**

Occupational issues were also important risk factors. These included Unproductiveness (OR 5.36); Occupational Problems (OR 4.11); Absenteeism (OR 2.70); and Unemployment (OR 1.76).

Among the factors that were associated with individuals' health status were Mental Illness (OR 10.29); Internal Distress (OR 9.60); Unhappiness in the two weeks prior to the act (OR 3.81); and Physical Illness (OR 2.35).

Child hood problems were also evident. The most important were Mental Illness in Childhood (OR 7.20); Single Parent (OR 2.36); Improper parenting (OR 1.86); Childhood problems (OR 1.81); and Discontinuation of Studies (OR 1.80).

Alcohol consumption on the part of the subject was identified as being a strong risk factor for suicide (OR 22.58).

Various forms of violence were also identified as risk factors. These included Domestic violence (OR 6.82) and Emotional abuse (6.93).

A history of previous suicide attempts was shown to place people at greater risk. Specifically, the factors identified were History of Attempted Suicide during the past year (OR 44.67);

*Continued on page 20*

# Suicide among Samoans living in New Zealand

**Jemaima Tiatia**
Injury Prevention Research Centre
University of Auckland, New Zealand

## Background

The Samoan ethnic group is the largest Pacific community in Aotearoa/New Zealand. It makes up 50% of the total Pacific population. According to the 2001 Census, 115,017 Samoan people lived in Aotearoa/New Zealand.

Almost all Samoan people in 2001 lived in urban centres, with two-thirds residing in the Auckland region.

Also according to the Census, proportionately more Samoans were born in Aotearoa/New Zealand than in the Islands. NZ-born Samoans accounted for 57%.

The Samoan ethnic group has been described as a youthful population. In 2001, 39% of Samoans were under 15 years of age, compared with 23% of the Aotearoa/New Zealand population.

## An overview of mortality and morbidity

In 1999, 514 people died by suicide across all age and ethnic groups in Aotearoa/New Zealand. Youth (15-24 years) had the highest rates for suicide (23.3 per 100,000 persons per year).

A total of 96 youth died by suicide in 2000. Representing 25% of all suicides despite making up only 14% of the total Aotearoa/New Zealand population.

Amongst Pacific peoples in Aotearoa/New Zealand, and across all age groups, suicide was the second leading cause of injury in 1996-98. A total of 54 Pacific suicide deaths were recorded for all age groups.

There were eight youth suicides reported for Pacific peoples in 1998 alone. 6 males and 2 females all of which were hangings.

Between 1993-98, suicide attempts were the third leading cause of injury hospitalisation amongst young people.

In 1999/2000, for all ethnic groups in Aotearoa/New Zealand and across the life span youth had the highest rates for attempted suicide (198.5 per 100,000 persons per year).

In 1999/2000, there were 356 male (rate of 131.4 per 100,000) and 698 female (rate of 268.3 per 100,000) hospitalisations for self-inflicted injury for youth.

Between 1996-99, there were 195 Pacific hospitalisations for suicide attempts across all age groups in Aotearoa/New Zealand.

Pacific youth made up 44% of all suicide attempts.

## A Samoan model of health

It is imperative when discussing Samoan health to first define the Samoan concept of health, which is expressed in the words soifua maloloina. Soifua translates as 'life', or 'to live', and maloloina means 'a rest', 'health', or 'to recover from illness'. The falefono (meeting house) presented in the Figure on this page is only one example in understanding the Samoan concept of health.

The Falefono, a Samoan concept of health model, taken from the New Zealand Ministry of Health's 1997 consultation document which looked at strategic initiatives for Pacific peoples' health was used to form the basis for this research.

The roof represents cultural values and beliefs, which is the shelter for life, and may include both traditional and Western methods of healing.

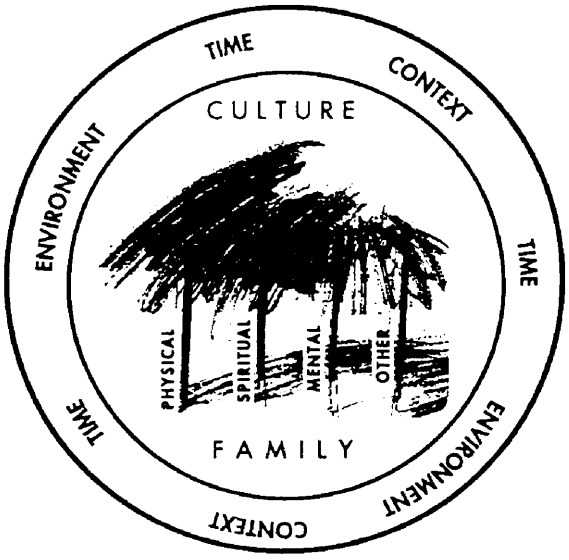
The foundation represents the nuclear family as well as the *aiga potopoto* (extended family). The *aiga* (family) provides the base which supports the four *pou* (posts): physical, spiritual, mental and other ('other' being, variables such as gender, sexual orientation, age and social class).

Surrounding the *falefono* is the social context in which health occurs, which for this research includes NZ-born Samoan young people.

## Aims of the study

The aims of the study were to:

- explore issues young NZ-born Samoan believed contributed to their suicide attempts.
- explore the reasons young NZ-born Samoan people who have attempted suicide believed would enhance their options to choose life and to thus contribute towards their overall future well-being (physical, mental, spiritual, emotional).
- provide information which may help in the planning of prevention strategies for agencies, and community organisations dealing with NZ-born Samoan and Pacific youth affairs in Aotearoa/New Zealand.




**Samoan model of health**

## Study design

The study had three phases:

1 A twelve month medical record review of Samoan young peoples who presented to emergency departments at Auckland public hospitals

*Continued on page 10*

# Suicide among Samoans living in New Zealand

**Continued from page 9**

2 In-depth face to face interviews with Samoan youth suicide attempters.
3 A qualitative focus on the prioritisation of the Samoan youth voice

## Phase 1: Medical record review

There were 27 young people who self-identified as Samoan; 6 identified with another ethnic group: Hawai'i, Niue, Tonga, Papua New Guinea.

**Gender:** Male (37%); Female (63%).
**Age group:** 16-19 (41%); 20-25 (59%).
**Occupation:** Employed (59%); Unemployed/Other (26%); Student (15%).
**Living arrangements:** Living with *aiga* (56%).
**Venue of attempt:** At home (67%).
**Day of presentation:** Weekday (67%); Weekend (33%).
**Time of presentation:** Monday to Friday 8.00 am to 5.00 pm (30%); Outside of office hours (67%).

## Phase 2: Interviews

The interviews followed three themes:

- *Aiga* (family)
- Emotions
- Reasons to Live

### *Theme 1: Aiga*

The core values of *Aiga* are *Fa'aaloalo* (respect); *Loto alofa* (love, compassion); *Fealofani* (harmonious relations); *Tautua* (service); *To'aga i le lotu* (commitment to Christian life and the church).

**Mata:**
*"Family is really important, without them you're nothing and they're always there for you at the end of the day, but man! Can they just give us a break! You know! Drive them here, there, pick up so and so and pay for this and that, look after the kids. It just gets too much and it hit me one day; all the bloody pressure. But you can't win cos if you don't do it you feel guilty for the whole day or week…In the end I couldn't balance everything at once, so I just did what I did - just kill myself or basically just wanting to escape."*

Mata's case is a negotiation of the core values as obligation takes precedence. Emerging from the theme of the *aiga* (family) are the various contradictions, such as:

- The changing nature of the aiga - disintegration of the extended family network (although not a new concept).
- physical discipline (this renegotiates the core value of *fa'aaloalo* or respect).
- Intergenerational misunderstandings between NZ-born and Island born.

**John:**
*"I find the most important thing about our family, is that even though people have moved away, we tend to come together when it's important issues like if there's a death in the family or a wedding or a birthday no matter where we are we travel and just come as one underneath the one roof, which I like because you get that real wholesome, real Samoan feeling. When your family is all around you, you feel protected and as one."*

At the same time the *aiga* is a protective factor and continues to be central in the lives of these young people. It didn't stop John from attempting to take his life—but what we see here is a concept on which to build upon—as stated "you get that real wholesome, real Samoan feeling" and "you feel protected and as one".

### *Theme 2: Emotions*

It seems from participant narratives that emotional repression can manifest itself to the point of self-destructive behaviours.

Comments by a few Samoan females addressed the view that the attempt to take lives was considered a means of releasing the 'pain' They reinforce the argument that young Samoan females are subjected to cultural constraints, more so than their male counterparts. Consequently, young Samoan females may have the least opportunity to express anger or hostility.

Shame had negative connotations. There was a connection between shame and the honouring of the family name. Fear of failure and the potential 'damaging' of the *aiga* reputation meant life choices were limited.

It was evident that the stringent cultural observance of self-control and *fa'aaloalo* (respect) by most Samoan young people as well as the expectation of knowing their place in the hierarchy, reinforced a tendency to mask emotions.

Whilst depression was identified as a contributing risk factor for some participants, of concern is that the majority considered the emotion of anger to be the primary catalyst to their suicide attempts.

### *Theme 3: Reasons to live*

**Fatu:**
*"I've learned to accept what I'd done and am letting it go. I keep thinking of all the reasons of why I should go on living and to be quite honest, it's mainly for my aiga (family). You see I lost a bit of myself when I tried to kill myself, and now I want to reclaim my life back."*

**Pologa:**
*"Spirituality is very important...I've made it a priority and that has been what's picked me up again. I have chosen to live cos God gave me another chance to live. My faith has helped me get back on my feet, kept me busy and helped me set goals for myself."*

**Solomona:**
*"Suicide should not be the only way out. There are some other good ways, without involving physical harm. There are better ways of coping or trying to get outta the shit. A biggie would be speaking to someone you can trust and being able to offload to them."*

Solomona's narrative suggests that the best approach to addressing suicidal behaviours is to talk through the problems with someone who is trustworthy. This, Solomona considers, is a coping mechanism to help alleviate stress.

## Concluding comments and implications:

- The implication is that *aiga* may be a young person's only unit of support, even if it may be a damaging environment.
- Cultural codes of conduct are a restriction.
- Youth programs might benefit by involving local religious and spiritual leaders. The inclusion of spirituality is consistent with the Samoan concept of health.
- Talking through issues is important: youth need to 'off load' their problems and concerns.

**Jemaima Tiatia, a Samoan who lives and works in New Zealand, can be contacted at the Injury Prevention Research Centre (IPRC), University of Auckland, Tel: +64 9 373 7599 extension 82385, E-mail: j.tiatia@auckland.ac.nz**

# Collaborative Eye Safety Project, Bangladesh 2002

**Steve Parker**
Noarlunga Safe Communities, South Australia

## About Sherpur

Bangladesh first became a country following the war of Independence in 1971. In area, it is a small country, but with a large population–135 million people. Dhaka, the capital, has a population of 13 million people, 94% of whom are of the Muslim faith.

Sherpur is a rural village area in the north east of Bangladesh, where people survive with the basic tools for small scale metal fabrication, welding and woodworking.

It is a place of poverty and child labour. Workplace injury through lack of personal protective equipment and safety standards can cast whole families into hunger and despair. If a person is incapable of work through occupational injury, there is no social security net and no means of affording even the most basic medical care.

## Background to Eye Safety Project

In February 2000, Stephen Parker, a community safety consultant with Noarlunga Health Services, presented a workplace safety paper at the World Health Organisation's 9th International Conference on Safe Communities in Bangladesh. During that visit he made contact with Dr Harun Or Rashid, the field coordinator of the Sherpur Safe Community Project. In 2001, Dr Harun was sponsored by Noarlunga Health Service to visit Australia with a special focus on the workplace health and safety program in the City of Onkaparinga which takes in some of Adelaide's outer southern suburbs.

During Dr Harun's visit, the need for an eye injury prevention project in Sherpur was identified and the process of thinking about a collaborative initiative to address this issue begun.

Sherpur has hundreds of small metal fabrication, welding and woodwork shops. In many of the small businesses, work is carried out in blacksmith's shops with old-style bellows, hammers and anvils and the workers have no personal protective equipment, such as safety glasses. In Bangladesh generally, when a worker receives an eye injury they often cannot afford basic medical treatment. A worker affected by occupational injury can quickly become unemployable and as a result his family suffers. As very little eye protection is worn, serious eye injuries are common.

*Inside a small business in Sherpur*

An effort was mounted among businesses in the City of Onkaparinga to donate safety glasses, welding helmets and oxy-acetylene goggles and the response was quite overwhelming. Enthusiastic local businesses donated 1,000 pairs of safety glasses and welding shields, which were presented to workers in Bangladesh in September 2002 during a series of workshops organised by Dr Harun. Students from the Morphett Vale East Primary School volunteered their time to clean the eye glasses.

*Children at Morphett Vale East Primary School cleaning eye wear to be sent to Bangladesh*

The Sherpur Safe Community Project invited Stephen to the workshops to provide technical assistance and, with the support of Noarlunga Health Services, STA Travel Trust, UVEX and Laubman and Pank, he was able to attend.

Following an extensive audit of small businesses by the Sherpur Safety Community Program, and months of careful joint planning, Stephen flew from South Australia to Dhaka, in September 2002. Stephen spent 10 days in very hot and humid conditions visiting small metal and wood working shops, and inviting employers and employees to a series of eye safety training sessions where eye safety glasses were given to participants. During these sessions, enthusiastic workers were instructed in the correct use of eye safety wear for welding, machining and grinding.

In total, over 250 workers attended the eleven workshops held at the Sherpur Safe Community Centre and over 500 pairs of new safety glasses were distributed to metal and wood trade workers. The intensive project visit also allowed for the vital training of Sherpur Safety Community health coordinators in workplace eye safety risk assessment.

The joint project also involved the development of culturally

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# Collaborative Eye Safety Project, Bangladesh

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appropriate educational safety information and signage for the small businesses in the Sherpur district.

Stephen found it to be a very fulfilling experience and one that demonstrated the generosity of small businesses in the City of Onkaparinga. The visit has created very special links and it is hoped that the project can be extended so that the need for safety protection for many of the children who work in the metal and woodworking shops in the Sherpur district can be addressed.

## Future directions

A vital consideration was to find ways of maintaining the Eye Safety project into the future. The donation of eye glasses from Australia was seen as a kick start for the initiative. Ideally,

*Drowning is a major problem in Bangladesh*

it will become possible to produce appropriate eye protection in Bangladesh. To meet local needs, such eye wear would need to be very inexpensive.

It was apparent from the visit that a focus is also required on the needs of child labourers. The poverty of people in Sherpur often dictates that their children must also work in order to sustain the family. Adult eye wear does not, however, offer effective protection for children.

*Eye safety workshop, Sherpur*

On an ongoing basis, it has been agreed that there will be an exchange of information and resources between the Safe Community programs in Noarlunga and Sherpur.

Stephen will return to Bangladesh to continue the work during February 2004.

**Stephen can be contacted at Noarlunga Safe Communities, Tel: 08 8384 9307; Fax: 08 8384 9727; E-mail: Parker.Steve@saugov.sa.gov.au or E-mail:**

# New RCIS Staff

**Sophie Pointer**

**Geoff Henley**

**Clare Bradley**

Sophie has worked in both government and university sectors and is an experienced researcher in a range of topic that include addition and alcohol. She is close to completing her PhD thesis through the Department of Psychology at Flinders University.

Geoff is a recent graduate of the Master of Public Health Program at the University of Adelaide.

Clare has a background in behavioural research and is in the final stages of undertaking a PhD in Environmental Biology through the University of Adelaide.

# Childhood injury prevention in Vietnam

**United Nations Children's Fund (UNICEF)**
**Vietnam**

## Background

In Vietnam, injuries are one of the main causes of death and disability in children aged over one year, and adolescents. The Vietnam Multi-center Injury Survey (VMIS), undertaken in 2001 by the Hanoi School of Public Health, indicated that the rate of fatal injury is 84.4 per 100,000 population. Drowning has the highest rate (41.2), followed by road traffic injury (13.75). Children under 14 are the most affected group. The rate of non-fatal injury for children and adolescents under 20 years of age is 4,901.5. The five most prominent causes of non-fatal injury were, in descending order, falls, animal bites, road traffic, sharp objects and burns. In some provinces, another cause of death and disability is unexploded ordinance (UXO) and landmines. According to the survey, almost 5% of children in Vietnam are injured in this way each year. Thus there is a death per every 50 severe injury cases with a considerable percentage of permanent disability.

Disabilities caused by accidents have imposed a considerable burden on the health sector in the form of resources needed for care, treatment and functional rehabilitation. Moreover, such disabilities create a psychological and socio-economic burden for individuals, their families, communities and the broader society.

Sociological studies show that one of the major causes of a high incidence of child injury is childcare givers' lack of necessary knowledge of how to protect their children. Children themselves are not guided and educated systematically on knowledge and measures to protect themselves from being injured and prevent accidents and injuries that may occur. In addition, environmental characteristics (both physical and social) in Vietnam such as abundant availability of open water, traditional means of cooking, etc. also contribute to the Country's injury burden. Other factors such as a lack of safety equipment in production, and poor safety of home appliances are also notable causes which help to increase the injury incidence in Vietnamese children.

Limitations in information, transfer and emergency systems also contribute to the high child injury death rate. Therefore it is necessary to have an active intervention program to improve awareness and change the attitudes of children, childcare givers and community leaders about safety and injury prevention.

This kind of program would contribute to the implementation, development and application of safety devices for children that are mainly produced from locally available materials, and develop model demonstrations of injury prevention for children. The implementation of demonstration projects in some provinces would also prove the efficiency of interventions for replication throughout the country.

In 1999, the Vietnamese Government and UNICEF, with technical support from the Center for Diseases Control and Prevention (CDC) Atlanta, initiated the Injury Prevention Initiative in Vietnam, called "*Safe Vietnam*". The initiative was designed to improve awareness, and change attitudes and behaviors of children, parents and policymakers on safety related issues and thereby reduce the incidence of injury mortality and disability. With commitment from the US Fund National Committee for UNICEF regarding further funding, since 2001 UNICEF has cooperated with agencies of the Vietnam Government to jointly develop an overall program for "Childhood Injury Prevention". This is the largest scale and most systematic program in injury prevention implemented by UNICEF on the global scale, for the first time. To date, Vietnam is one of the first developing countries to implement an overall and comprehensive program on injury prevention.

## The UNICEF Childhood Injury Prevention Program

The overall goal of this program is to contribute to the implementation of the National Policy on Accident and Injury Prevention 2002 - 2010 and the National Program of Action for Children 2000-2010. Over a period of 5 years (2001-2005), the program will endeavour to create awareness among people in all communities across the nation, to reduce the incidence of major injuries in Vietnamese children aged under 18 years of age, focus on accidents and injuries at home, in communes, and in schools; to reduce by 25% the number of deaths caused by injury in target provinces.

The program is divided into two components:

### *1 Injury prevention activities integrated into on-going UNICEF programs*

Since 2001, injury prevention activities were integrated into existing UNICEF country program activities across Health and Nutrition, Education, Communication, Water and Sanitation, and Child Protection and Rights Promotion strands. For example, within the Health and Nutrition strand was added activities in support of the development of a National Policy on Injury Prevention. The National Policy was launched at the first in a series of National Conferences in December 2002. In a further example, a new child injury prevention curriculum was integrated into the existing curriculum for primary eduction. The activities which make up the new curriculum aim to raise the awareness of teachers with respect to injury and equip them with methods for teaching children about the issue. Also as part of the existing program, a large number of mass media activities has been developed. Examples of these include collaboration with Vietnamese television and radio broadcasters to produce programs on injury prevention; game shows on the theme of child injury prevention, support for the training and activities of Youth Union volunteer communicators on child injury prevention.

A number of UXO/landmines has also been undertaken in UNICEF Vietnam to raise awareness of children and community on the dangers of UXO/ landmines, to support data collection activities in affected areas and to support the victims.

### *2 Childhood Injury Prevention (CIP) as a new comprehensive project*

Although many injury prevention activities have been integrated into existing UNICEF projects, it was considered important to complement this with a highly visible, stand-alone project that would maximise its impact. Furthermore, it was felt that a dedicated

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# Childhood injury in Vietnam

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project would provide the means for coordinating all injury prevention activities and would assist people in advocating for the broad involvement of different organisations and sectors. The result is the *Childhood Injury Prevention project* which was created in 2002 with the following objectives:

- To create and increase awareness and help to change the attitudes of children, parents/childcare givers, community leaders on safety and injury prevention
- To establish and implement model demonstration projects on child injury prevention and develop safety devices for children in target provinces.

## Project strategies

***Public education through mass media:***

The project will carry out public communication and education activities on child injury prevention nation wide through information and education programs.

- Entertainment programs will be in different formats including development of knowledge disseminating programs such as game-based programs or other entertainment programs on TV and Radio.
- Mass media at all levels and different communication channels will be utilized at maximum level to create awareness and introduce knowledge of injury safety to households, to target groups and to people having influences on the target groups.
- Participation of communities and social/mass organisations in communication will be promoted and strengthened.
- Establishment of model demonstration and development of safety devices
- Reliable database will be developed based on qualitative and quantitative surveys in the community in order to identify pivotal communes and districts and specific priorities for implementing intervention models, aiming at changing the physical environment surrounding children to reduce child injury risks.
- Technical capacity building for all project staff levels will be emphasized in order for them to carry out the project activities effectively.
- The development, provision and application of model demonstrations such as *Child Safe Home*, *Child Safe School*, *Child Safe Kindergarten* will be carried out in six provinces: Hai Phong, Hai Duong, Quang Tri, Hue, Dong Thap and Can Tho.
- The development, provision and application of safety devices will be implemented in combination and integration with the model demonstration.

**UNICEF Vietnam can be contacted at 2 Ngo Quyen, Hanoi, Vietnam, Tel: +844 935 0028, Fax: +844 935 0040, E-mail: ntyduyen@unicef.org**

# Suicide and risk-taking deaths of children and young people

A recent study by the NSW Child Death Review Team examined the deaths of 187 children and young people aged 12 to 17 years who died in NSW from suicide and risk taking in the five year period, January 1996 to December 2000. The report on this study, which goes by the title *Suicide and risk-taking deaths of Children and Young People*, includes the following key findings:

- ***Suicide and risk-taking deaths are rare:*** Over the five-year period, the highest death rate occurred in 1997, which was 9 deaths per 100,000 young people aged 12-17 years in NSW. However, while infrequent, suicide and risk-taking are significant causes of death in the 12-17 year age group. In the five year period of the study, suicide and risk-taking deaths made up almost one quarter of deaths of young people from all causes in NSW.
- ***Gender is significant:*** Males are represented in deaths from all causes. This is also true for suicide and risk-taking deaths. Over the five-year period, the majority (71.1%) of young people who died from suicide or risk-taking were males.
- ***Young people in rural areas are not over-represented:*** In contrast to some existing literature, the study found that young people living in rural and remote areas were not over-represented in suicide and risk taking deaths. This difference is most likely explained by the fact that literature documenting an increased suicide risk in rural areas tends to refer to the 15 to 24 year age group rather than the 12-17 year age group that was the population of this study.
- ***Aboriginal children and young people are over-represented:*** Aboriginal children and young people are over-represented in deaths from all causes. Similarly, Aboriginal young people were over-represented in suicide and risk-taking deaths. Although only 2.8% of the NSW population of young people aged 12-17 years are Aboriginal, 7.5% of those who died from suicide or risk-taking were Aboriginal.
- ***Children and young people often tell others of their suicidal intentions:*** Young people often informed a friend or family member of their intention to commit suicide. In almost every case, the person informed did not act on the information, either because they did not take the suicide threat seriously or because the child or young person insisted they promise not to tell anybody. The belief that people who talk about committing suicide 'never do it' is one of the myths about suicide. People need to know that suicide threats are secrets that must not be kept.
- ***Young people who die in this way are not a homogenous group:*** Based on the life histories of the young people and the events leading up to their deaths, three groups of suicide and risk-taking deaths emerged:
  1. 124 young people, who died by both suicide (n=80) and risk-taking (n=38), experienced enduring difficulties (mental health problems, family dysfunction, or school-related difficulties)*;
  2. 26 young people, all but two of whom died by suicide, experienced a pivotal life event, such as interpersonal issues and unemployment; and
  3. 28 young people, all but one of whom died by risk-taking, died as a result of adolescent experimentation. None appeared to have experienced enduring difficulties or a pivotal life event.

  *intent could not be determined for 6 cases.

**For details about obtaining a copy of the report, see page 19.**

STRATEGIC INJURY
PREVENTION PARTNERSHIP

# Communique

16-17 March 2003

The 8th Meeting of the Strategic Injury Prevention Partnership was held in Perth on 16-17 March 2003. Members attending the meeting were Rod McClure (Chair), James Harrison (AIHW), Michael Callan and Kerry Smith (Commonwealth & SIPP Secretariat), Richard Franklin (AIPN), Pam Albany (NSW), Paul Vardon for Michael Tilse (Queensland), Nicole Bennett (WA), Ron Somers (SA), Nicola Rabot (Victoria), Stan Bordeaux (TAS) and Tarun Weeramanthri (NT). Also in attendance were Sandy Brinsdon (Ministry of Health, NZ), Margaret Thomas (Victoria), Bec Paddick and Belinda Brandon (Commonwealth) and Linda Parsons and Hazel Hopkins (WA).

Several invited guests attended for brief periods. These were members of the Australian Injury Prevention Research Institutions of Australasia, Kerryn Mulvenna (NCIS), Sophie Pointer (NISU) and Jerry Moller (New Directions in Health and Safety).

Apologies were received from Anna Perkins (ACT), John Wunsch (Consumer Affairs), John Scott (Co-Chair).

## Updates from jurisdictions

### *Western Australia*

Nicole Bennett reported that her unit is working with the Princess Margaret Hospital Emergency Department to collect data on paediatric injuries. This is the only paediatric hospital in Perth. She also reported that her unit is leading the complementary business planning in consultation with the Area Health Services' Population Health units, injury prevention non-government organisations and sections of the Department of Health including Office of Aboriginal Health and the Office of Rehabilitation and Aged Care. The injury prevention health sector has an increased number of partnerships that are increasing the effectiveness and efficiency of injury prevention activity in WA. An independent consultation on the development of the WA Water Safety Plan has raised several issues of concern which will need to be addressed regarding specific roles of stakeholders.

### *Tasmania*

Stan Bordeaux reported that his State relies on non-government organisations to implement a lot of the injury prevention work. Issues at the national level of Kidsafe have therefore interrupted the work of the Tasmanian office of Kidsafe. Stan reported that the Falls Demonstration project is progressing well and is based on a system change approach. The Emergency Department of the Royal Hobart Hospital is trialing an early identification of non-admitted fallers and installing a referral system to their GPs for further intervention and referral as required. A second component of the project, having GPs use Enhanced Primary Care Packages to identify high risk fallers, is currently having limited success, but the team is working closely with the Divisions of General Practice to facilitate this important project.

### *South Australia*

Ron Somers reported that his Unit has been working on a number of issues of interest to SIPP members. These included the proposed National Poisoning Prevention project with the Commonwealth and the Therapeutic Goods Administration; and the expansion of the SA Trauma Registry to improve its clinical quality. Ron's Unit also recently identified a dangerous cot and has had this banned under the Trade Practices Act. Ron also raised a number of issues of concern that his Unit was investigating:

- dementia and driving – this is a big issue as the current test doesn't include a cognitive measure;
- the issue of booster seats for toddlers being made mandatory;
- above ground pools are not covered by the Building Code;
- universal leashing for dogs in public places;
- evaluation of the law requiring helmet use by skaters and skateboarders on public roads; and
- cheap refillable lighters do not require child resistant mechanisms.

### *Commonwealth*

Michael Callan reported that the National Falls Prevention in Older People Initiative had been reunited with the Injury team. This has created the opportunity for several new staff and a recruitment process was currently underway. The Injury team is linking with other sections and teams within the Drug Strategy Branch to investigate opportunities for joint projects.

### *New South Wales*

Pam Albany reported that a considerable budget has been promised for the rollout of the NSW policy for falls prevention in older people. Pam also reported that the Aboriginal Health Partnership has signed off on the NSW Aboriginal Safety Promotion Strategy. This strategy can now be implemented, with funding sources to follow. Pam reported that she has been involved in developing a national Safe Communities Foundation, although progress has been slow. The NSW Fire Brigades are interested in expanding their community safety role in this area. The contract with the Injury Risk Management Centre of NSW has been finalised. This group will provide research and policy advice to the NSW government on injury risk management.

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SIPP
STRATEGIC INJURY
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# Communique

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### *Queensland*

Paul Vardon (for Michael Tilse) reported that in response to the recent release of a coroner's report on the drowning death of a child, the Department of Local Government and Planning has surveyed all local governments on pool fencing compliance. Since then, three local Governments have hired staff to perform regular compliance checks and are trialing pool inspection guidelines. Given renewed interest, the development of a Queensland Water Safety Plan is being progressed and is hoped will be endorsed by key stakeholders in the near future. The Statewide Action Plan: Falls Prevention in Older People 2002-2006 has been released and is being implemented across the State. It will provide a forum for activity across settings and across districts. Injury Prevention has been identified as an area which needs more investment in the recent Smart State: Health 2020 document. Queensland Health is actively participating in a number of key initiatives in partnership with other State Government Departments (Emergency Services and Housing) including safe housing and injury prevention. Given limited resources and incentives, injury surveillance data collection in Emergency Departments remains an ongoing issue. Given the organisational nature of community health in Queensland, working effectively at a statewide level is problematic.

### *Victoria*

Nicola Rabot reported that Community Safety Month had gone very well with a large injury prevention focus and activities at various levels. The Safe Start program for child injury prevention is now being run at three demonstration sites. This project engages community level participation in injury prevention. The Victorian Child Injury Prevention Strategy is currently being developed and will go to consultation before it is finalised. Nicola reported that they are still having limited success in getting injury prevention on the agenda of Indigenous organisations in Victoria. Margaret Thomas reported that Victoria is supporting several falls prevention projects across a range of settings.

### *Northern Territory*

Tarun Weeramanthri reported that pool fencing legislation was introduced on 1 January 2003, requiring Australian Standards fencing for new pools, and when properties are sold, or upon change of tenants in rental properties. To encourage existing pool owners to upgrade fencing, a cash bonus and interest free loan scheme has been introduced for a period of 18 months. This initiative is part of a broader focus on water safety education and awareness, with a scheme being planned to provide vouchers for swimming lessons for pre-schoolers and their parents. NT is also currently developing a Water Safety Plan. The NT has recently received significant funding from the Rural Health Branch of the Commonwealth Department of Health and Ageing to fund Kidsafe NT to develop guidelines and associated educational materials for child injury prevention in remote communities.

### *Australian Injury Prevention Network*

Richard Franklin reported that the 6th National Conference on Injury Prevention and Control looked like being a success. AIPN is considering underwriting issues for future conferences. AIPN's new website has been completed with a new format and more material. In addition, it has added a list of injury prevention courses. The website address is www.nisu.flinders.edu.au/aipn/ AIPN has appointed an Indigenous Liaison Officer to their National Executive and is investigating the possibility of providing mentoring for an Indigenous person.

### *National Injury Surveillance Unit*

James Harrison reported that some internal issues within the Unit had affected productivity over the past year, and that these had now been addressed with several new staff members on board. Most projects were on track, but they were experiencing delays in receiving some hospital and ABS data which may affect timelines for some reports.

### *New Zealand*

Sandy Brinsdon reported that the NZ Injury Prevention Strategy will be released in June 2003. It has received positive feedback from stakeholders and will be available on the following website: www.nzips.govt.nz Sandy also provided copies of the newly released Health of Older People Strategy available from the Ministry of Health website: www.moh.govt.nz Statistics New Zealand has been appointed Injury Information Manager from 1 July 2003. This involves coordinating the production of official injury statistics across agencies that produce data and providing a program of statistics and information services based on the integrated database.

### *NSW Falls Policy*

Pam Albany gave a presentation to SIPP on the NSW Falls Policy. The ageing population means that NSW will require four new 200 bed acute care facilities and an additional 1,200 nursing home places by 2051. However the impact of the ageing population will commence in nine years' time. The Falls Policy considers managing personal risk factors for fall injuries from younger years to older age groups, managing environmental risks, better coordination of services and coverage of prevention strategies, workforce training, and developing and maintaining a research and evaluation focus to improve understanding of

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STRATEGIC INJURY
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# Communique

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best practice in fall injury prevention. It provides for older people in the community, in acute care and residential aged-care facilities. Pam is interested in discussing partnerships with other jurisdictions for research and evaluation relating to the policy. More information on the policy is available at www.health.nsw.gov.au/public-health/health-promotion/improve/injuryprev/index.htm

### *NSW New Surveillance Technology*

Pam Albany provided a presentation prepared by Tim Churches and Louisa Jorm of the Epidemiology and Surveillance Branch of NSW Health on the emergency department (ED) surveillance for the Sydney 2000 Olympic games and text data mining techniques for Emergency Department injury surveillance. The purpose built data base was used in 15 sentinel EDs over a 38-day period. A number of target conditions, including injuries occurring outside the home, were included. Although communicable diseases were the main focus in planning, no outbreaks were detected. The main incidents prompting public health responses during the Games were related to injury. There was an increase in presentations relating to cuts by glass at an ED close to the Olympic sites. As a result glass containers were withdrawn from sale at these sites. There were frequent presentations for injuries relating to foot-propelled scooters, mainly in children and associated with school holidays. SOCOG was alerted about this issue and scooters were banned from venues. There were three presentations for *grand mal* seizures associated with ecstasy use in one night, and this prompted warnings to all EDs. Text mining is an extension to unstructured textual data searches and a systematic method of identifying issues of interest or concern.

### *Development of Priorities for a new National Injury Prevention Plan*

The National Injury Surveillance Unit (NISU) is preparing a report for the Commonwealth Department of Health and Ageing to identify potential priority issues for the next National Injury Prevention Plan. The draft *Options* document was presented by James Harrison, Sophie Pointer and Jerry Moller. It provides a contextual basis for considering topics, and proposes and describes a set of topics as possible priorities for discussion. The topics for consideration for 2003 and beyond consist of five broad-based population topics (elderly 75+, children aged 0–14, emerging adults aged 15–24, rural and remote population) and one risk factor based topic (alcohol and injury). Members provided feedback to NISU on the draft report and were supportive of the general direction being taken.

### *Injury Prevention Research Institutions of Australasia (IPRI)*

SIPP members met informally with IPRI members during the SIPP meeting and discussed the potential for formal liaison with this group. SIPP members agreed that it may be beneficial to hold a joint meeting in the future and provide a joint statement to the National Public Health Partnership on issues relating to injury research.

### *National Coronial Information System*

Kerryn Mulvenna from NCIS provided SIPP members with an information session on the recent developments with the system. Members agreed that NCIS was an extremely valuable research and planning tool for injury prevention and supported its use.

### *Strategic directions of SIPP*

SIPP agreed to a review of the current terms of reference and governance arrangements and will progress this over the next few months.

### *Workforce Issues*

Members of the workforce project based at the University of WA and currently 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. SIPP members have previously given in-principle for this project. Several SIPP members also indicated that their respective jurisdictions would provide a financial contribution to this project as per the AHMAC cost-shared formula. Members noted that Michael Tilse (Queensland) will represent SIPP on the project Reference Group.

### *Joint projects*

SIPP is continuing discussions on providing background issues papers on specific injuries for the use of Coroners in their investigations of injury-related deaths. Members agreed to auspice the National Poisons Prevention Initiative, a joint project between the Injury Surveillance and Control Unit from the South Australian Department of Human Services and the Injury Prevention section of the Commonwealth Department of Health and Ageing. This project will include an assessment of the child resistance of pharmaceutical products sold in non-reclosable packaging.

### *Future meetings*

SIPP meeting dates for 2003 are:

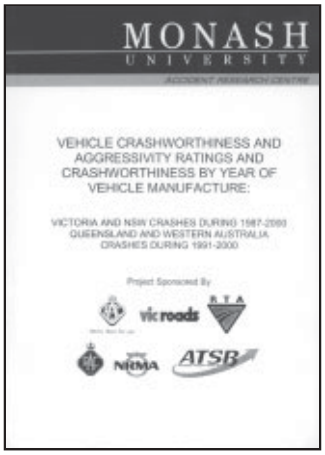
- 26 August 2003 by teleconference
- 18/19 November 2003 in Melbourne.

### *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 contact the SIPP Secretariat at kerry.smith@health.gov.au

# Something to read ...?

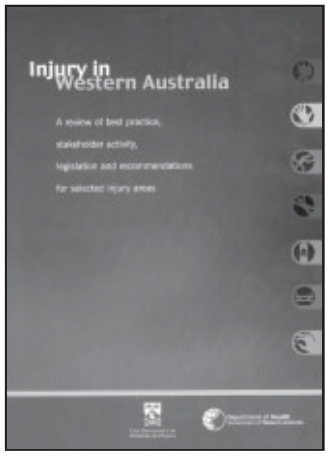
## Vehicle crashworthiness ratings




Under its full title, *Vehicle Crashworthiness and aggressivity ratings and crashworthiness by year of vehicle manufacture*, this report by the Monash University Accident Research Centre details measures of relative safety of vehicles in preventing severe injury to their own drivers in crashes and measures of the serious injury risk that vehicles pose to drivers of other vehicles with which they collide. Both measures are estimated from data on real crashes.

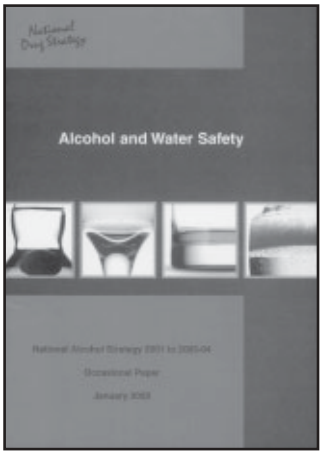
A copy of this report is available on the Internet: www.general.monash.edu.au/muarc/rptsum/ab196.htm Inquiries about printed copies can be directed to MUARC, Tel: (03) 9905 4371, Fax: (03) 9905 4363.

## Injury in Western Australia




This document is the first in a series which aims to assist practitioners in conducting injury prevention and control programs. The selected areas of injury included in the document are Burns and Scalds; Drowning; Falls in the Elderly; Falls in Children; Poisoning in Children; Road Crashes; and Suicide. Copies of each of the above sections can be downloaded from the Internet: www.population.health.wa.gov.au/promotion/resources_promotion.cfm#injury Printed copies can be ordered from the Department of Health, Tel: 08 9222 2088 (quote the order code HP8228).

## Alcohol and Water Safety




This report is described in detail in our article on page 1. Copies are available on the Internet: www.health.gov.au/pubhlth/publicat/document/alcwater.pdf Printed copies can be obtained, free of charge, from the Injury Prevention Section in the Department of Health and Ageing, Tel: 02 6289 8074; E-mail: phd.publications@health.gov.au

## 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.
Editor: Renate Kreisfeld

Mark Oliphant Building, Laffer Drive, Bedford Park, SA 5042, Tel: 08 8374 0970; Fax: 08 8374 0702;
E-mail: r.kreisfeld@flinders.edu.au

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Health and Ageing

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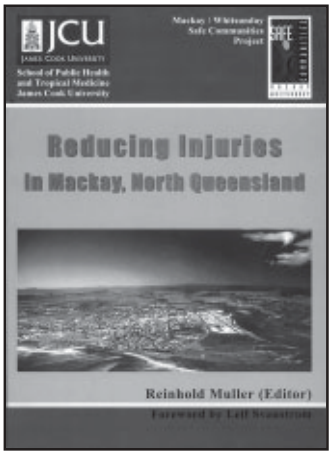
# Something to read ...?

## Development of the NSW Child Health Survey 2001

This supplement to the NSW Public Health Bulletin outlines the methodology used by the NSW Child Health survey which was designed to address information deficits and priorities for child health at the state and national levels. Copies of the supplement are available on the Internet: www.asnsw.health.nsw.gov.au/public-health/phb/childdevsurvey2001.pdf

## Reducing Injuries in Mackay, North Queensland

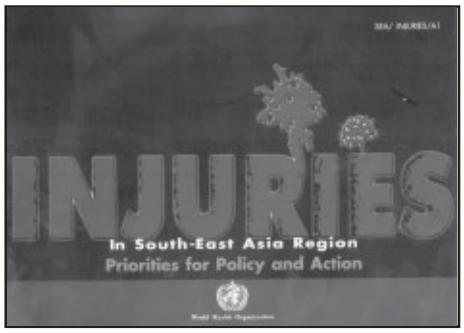



Prepared by the School of Public Health and Tropical Medicine at James Cook University, this monograph outlines the results of a collaboration between the University's Injury Research Group, the Mackay Health Service District and the Queensland Injury Surveillance Unit. The partnership was created to perform detailed needs assessments for the Mackay Region and to develop, implement and evaluate the strengths and limitations of specific injury prevention program. This collaboration is expected to provide a much-needed template for injury prevention in other rural Australian communities. Copies are available on the Internet: www.wepi.org/rimnq/contents.html Inquiries about printed copies should be directed to Warwick Educational Publishing Inc, 11 Finch St, Warwick QLD 4370, Email: secretary@wepi.org

## Suicide and risk-taking deaths of children and young people

Copies of this report are available on the Internet: www.kids.nsw.gov.au/publications/suiciderpt.html#pdf Enquiries about obtaining a printed version of the report should be directed to Trish Malins or Melissa Sankey at the NSW Commission for Children and young people on Tel: 02 9286 7276, E-mail: kids@kids.nsw.gov.au

## Injuries in South-East Asia




*Injuries in South-East Asia Region: Priorities for Policy and Action* is a recent publication of the World Health Organization. The document has been prepared by Dr Dinesh Mohan of the Indian Institute of Technology in Delhi and Dr Mathew Varghese, Director of St Stephen's Hospital in Delhi.

Copies of this publication are available from Disability/ Injury Prevention and Rehabilitation, World Health Organization, Regional Office for South-East Asia, Mahatama Gandhi Marg, New Delhi 110 002, India and via the Internet: w3.whosea.org/dpr/pdf/injuries-a1.pdf

## Statistics on drug use in Australia 2002


The latest in the series of reports from the AIHW is now available on the Internet: www.aihw.gov.au Printed copies can be obtained, free of charge, from the Population Health Division of the Department of Health and Ageing, Tel: 02 6289 8360, Fax: 02 6289 8654, E-mail: phd.publications@health.gov.au

# 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/

**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/

**Inhalant Use & Disorder**
*7-8 July 2003*
*Townsville, Queensland*
Contact: Conference Co-ordinators, Tel: +61 2 6292 9000 Fax: +61 2 6292 9002 E-Mail: confco@austarmetro.com.au Website: www.aic.gov.au

**Graffiti and Disorder: Local Government, Law Enforcement and Community Responses**
*18-19 August 2003*
*Brisbane*
Contact: Conference Co-ordinators Tel: +61 2 6292 9000 Fax: +61 2 6292 9002 E-Mail: confco@austarmetro.com.au Website: www.aic.gov.au

**International Surgical Week ISW03**
*24-28 August 2003*
*Bangkok, Thailand*

**Contact: Secretariat ISW03, Tel: +41 61 815 96 67 ; Fax: +41 61 811 47 75; E-Mail: surgery@iss-sic.ch Website: www.iss-sic.ch**

**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

**Third European VitreoRetinal Society Congress and Sixth International Society of Ocular Trauma**
*3-16 September 2003*
*Sopron, Hungary*
Contact: Ferenc Kuhn, Tel: +1 205 558 2588; Fax: +1 205 933 1341 E-Mail: fkuhn@mindspring.com Website: www.evrs.org/pages/meetings.htm

**XXII Congress of the International Association for Suicide Prevention (IASP)**
*10-14 September 2003*
*Stockholm, Sweden*
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

**47th Annual Conference with a Special Session on Injury Scaling and Outcomes**
*22-24 September 2003*
*Lisbon, Portugal*
Contact : AAAM, Tel: +1 847 844 3880; Fax: +1 847 844 3884; E-mail: aaam@carcrash.org Website: www.carcrash.org

**17th Annual California Conference on Childhood Injury Control**
*22-24 September 2003*
*Los Angeles, California*
Contact: Conference Co-ordinators, Center for Injury Prevention Policy and Practice, San Diego State University, Tel: +(619) 594 3691 Fax: +(619) 594 1995 Website: www.cippp.org

**2003 Road Safety Research, Policing and Education Conference**
*24-26 September 2003*
*Darling Harbour, Sydney*
Contact: Conference Organisers, ICE Australia Pty Ltd, Tel: 02 9544 9134; Fax: 02 9522 4447; E-Mail: rta@iceaustralia.com Website: www.iceaustralia.com/rta

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

**Safety Promotion Research—A Public Health Approach to Accident and Injury Prevention**
*13-23 October 2003*
*Stockholm, Sweden*
Contact: Marjan Vaez, Karolinska Instituet, Tel: +46 8 517 793 57; Fax: +46 8 33 4693; E-Mail: marjan.vaez@smd.sll.se Website: www.ki.se/phs/education/

**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

*Safety Promotion and Injury Prevention*
*3-13 November 2003*
*Stockholm, Sweden*
Course of study.
Contact: Moa Sundstrom, Karolinska Instituet, Dept of Public Health Sciences, Division of Social Medicine, Tel: +46 8 517 779 48; Fax: +46 8 33 46 93; E-Mail: moa.sundstrom@smd.sll.se Website: info.ki.se/education/forms/courses.pdf

**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

**7th Australian Injury Prevention Conference and Pacific Rim Safe Communities Conference**
*15-17 September 2004*
*Mackay, Queensland*
Contact: Maria Lamari, Conference Secretariat, PO Box 3090, Norman Park QLD 4170, Fax: +617 3847 2148, Website: www.nisu.flinders.edu.au/aipnconference2004

# Suicides in Bangalore, India

**Continued from page 8**

Family History of completed Suicide (OR 6.39); and Family history of both attempted and completed suicide (OR 4.51).

An absence of positive protective factors was also important. Most notably, the absence of a Positive Outlook on Life (OR 281.53); Problem Solving Skills (81.60); Coping Skills (OR 43.51); and Life Satisfaction (OR 31.65) placed people at greater risk.

An attempt was made in the study to identify broadly defined causes of suicide. These included Marital problems (10.14); Educational problems (OR 5.87) and Family problems (OR 5.10).

After identification of risk factors, the prioritised factors have been discussed with various agencies to select major ones for intervention.

**Dr Gururaj can be contacted at the National Institute of Mental Health and Neurosciences in Bangalore, Tel: +91 080 6995245, E-mail: guru@nimhans.kar.nic.in**

## References

1 Bangladesh Demographic and Health Survey (BDHS).

2 Health and Science Bulletin, ICDDR,B 2001.

3 Vijayakumar L, Rajkumar S. Are risk factors for suicide universal? A case-control study in India. Acta Psychiatrica Scandinavica, 1999; 99: 407-411.