INJURY ISSUES MONITOR

In this issue ...

Update on injury deaths in Australia

In 1998, a total of 7,946 deaths (6% of all deaths) were the result of an external cause of injury or poisoning. These included 5,614 males and 2,332 females. Injury and poisoning was the leading cause of death for persons aged under 45 years, accounting for 48% of all deaths for people in that age group. Almost one-quarter of people dying from injury were young men aged 20 to 34 years.

Suicide accounted for the largest proportion of injury deaths followed by injuries due to road traffic crashes. Despite a large reduction since 1970, road deaths remain a common cause of injury-related deaths. Accidental falls ranked third among commonly reported categories of injury death

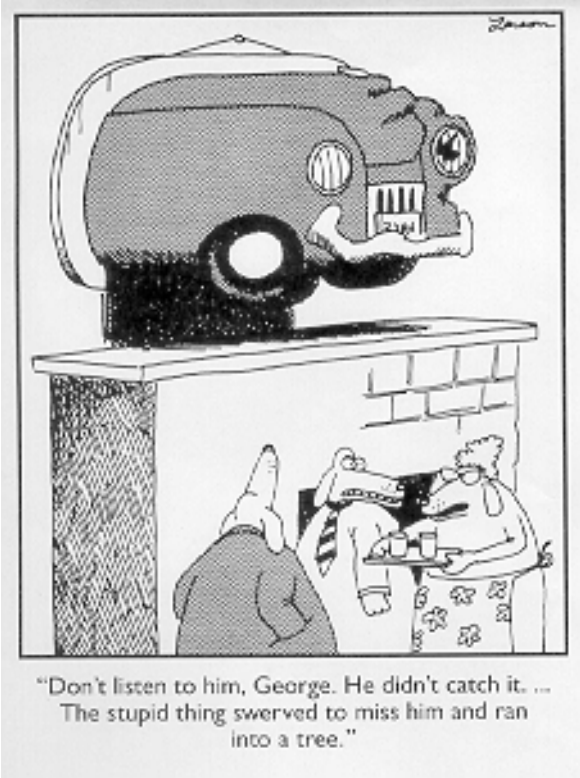
For nearly all types of injury, death rates are higher among males than females. Overall, injury death rates are the highest among young males, and both males and females in old age.

Trends in injury-related deaths

A long-term time-series is available for injury-related deaths.

The overall death rate for injury declined during the second half of the twentieth century, broadly in step with the decline in all-causes death rate. All through this period, injury has accounted for 7-8% of male mortality and for 4-5% of female mortality. During the middle

Continued on page 2



"Don't listen to him, George. He didn't catch it. ... The stupid thing swerved to miss him and ran into a tree."

This time Delhi ... next stop Montreal

The 5th World Conference on Injury Prevention and Control has just concluded in New Delhi, India. Under the theme *Sharing experiences: Blending perspectives*, it was the first in the series to be held in a low income country.

The Conference was well attended—711 people registered. Of particular note, too, was the fact that the meeting attracted the largest participation from African and Asian countries of any of the conferences to date.

Taking place over four days, the Delhi conference included several parallel symposium sessions, state-of-the-art lectures, plenary and round table sessions. This made for a very packed and varied program. There were also a number of business meetings in the evenings, as well as pre- and post-conference meetings.

The plenary and state-of-the art lectures have been incorporated into a book entitled *Injury Prevention and Control*. It was edited by Dinesh Mohan and Geetam Tiwari and published by Taylor and Francis, London.

As has become the custom, the Delhi Conference provided the forum for the official announcement of the dates and venue for the next Conference in the Series. The 6th World Conference

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Update on injury deaths in Australia

(continued from page 1)

and late 1990s, however, total injury death rates remained more or less static, whereas all-causes death rates continued to decline at 1-2% per year.

Varying temporal trends have been noted in death rates for major types of injury. Over the long term, no sustained underlying trend has been noted for all-ages suicide rates. An increase in suicide rates occurred in the 1960s, when suicide using pharmaceutical substances (especially barbiturates) rose. Death rates for motor vehicle crashes rose with the emergence of this mode of transport in the first half of the century, dipping with the reduced use of motor vehicles during the Great Depression and the Second World War. Strong and sustained response to the epidemic began in the 1960s and has had great success. Despite continued rises in vehicle numbers and the distance travelled, case numbers and population-based road injury death rates declined sharply after 1970. Mortality from all other types of injury, taken together, also declined substantially during the twentieth century.

Two categories of injuries showing upward trends in death rates lately are suicide among males and deaths related to opiate drugs.

Male suicide rates in 1997 and 1998 were the highest since the 1960s. The female suicide rate on the other hand has remained close to 5 per 100,000 population for two decades, but rates are rising among young women.

Opiate drugs-related deaths, alone or in combination with other causes, are also rising rapidly.

Suicide

Suicide became a matter of national public health concern in Australia during the 1990s. Initially the focus was on youth suicide, prompted by the observation that rates at young adult ages had risen about three-fold during the thirty years to 1990. By that time rates for young men were similar to those of older men, lower rates being seen in middle age.

More recent data show two changes to this pattern. First, rates for young adult males have continued to rise. Second, the cohorts of men who were noted to have high suicide rates when they were aged in their early 20s—in the 1970s and 1980s— have continued to have high rates as they have grown older. In the late 1990s, suicide rates were high for men aged from about 20 to 40 years.

Hanging has become the predominant method of suicide in Australia, and its use is accelerating. Hanging has been the commonest suicide method for males since the early 1990s and for females since 1997. Rates remain much higher for males than females, but are increasing for both genders. The birth cohort pattern underlying the overall rise in suicide rates, described above, is particularly pronounced for hanging.

The increase in hanging suicide more than accounts for the total rise in suicide rates in recent years. Hanging comprised 12% of all suicides registered in 1980, 25% in 1990 and 44% in 1998. The 1,184 suicide deaths by hanging registered in 1998 are 15% of all external cause coded deaths, up from 2% in 1980. In 1998 the number of hanging suicides was about the same as the number of deaths attributed to accidental falls (n=1182) and more than two-thirds of the number of deaths due to motor vehicle traffic accidents (n=1731).

The other marked changes in occurrence of suicide by particular means are a reduction by more than half in the rate of suicide by shooting since the late 1980s, and an increase of about 20% in suicide by motor vehicle exhaust gas.

Opiate related deaths

Poisoning by opiates and related narcotics was mentioned as a cause of 1,077 deaths registered in Australia in 1998, of which 111 were recorded as suicides. In the same year, 992 deaths were coded to one of the underlying causes of death to which opiate-related cases other than suicides are usually coded (ICD-9 codes 304.0, 304.7, 305.5, E950.0 and E958.8).

Mortality rates for deaths coded to these categories have risen greatly since the early 1980s, especially for young adults. The death rate for categories that include—but are not restricted to—suicides by opiates (E950.0, E950.4) have also risen, though less rapidly, from about 0.5 deaths per 100,000 in the early 1980s to about 1.0 in the late 1990s.

This cause of mortality has become prominent in birth cohorts that have reached adulthood since about 1980. Rates have risen for both genders, though they are much higher for males than females.

Conceptual issues and coding practice complicate monitoring trends of deaths associated with heroin and other opiate drug use. For example, should attention be limited to deaths in which opiate poisoning was clearly the cause of death, or should deaths involving multiple drugs, including an opiate, be included? A similar question concerns deaths associated with opiate use from causes other than opiate poisoning. Recent introduction of multiple cause coding of deaths has improved the possibility of identifying cases in which opiate poisoning is involved. However, associated changes in coding practice have complicated the interpretation of trends.

Inquiries about this article should be directed to James Harrison at the RCIS, Tel: 08 8374 0970; E-mail: James.harrison@nisu.flinders.edu.au

Measuring and characterising injury in Australia

The AIHW National Injury Surveillance Unit has undertaken a project to investigate and test the feasibility of injury surveillance based on case collection at emergency departments (EDs) which would (1) enable national quantitative monitoring of injury occurrence, and (2) provide case information sufficient to characterise the many types of injury case that are of interest to data users. The project was funded by the Department of Health and Aged Care.

An overview of the major findings of the project is presented here. The report will be available soon.

Measuring:

Surveillance based on emergency department cases and capable of monitoring national incidence rates and trends for injury generally, and for particular types of case, requires:

1. A system capable of monitoring injury attendances to EDs with sufficient precision; and
2. A way to account for the large and possibly changing proportion of injury cases not seen at an ED.The first aspect is technically feasible, based on collection of data at a probability sample of about 40 or more emergency departments. Under optimal conditions, a system would be capable of detecting changes of about 20% from year to year in types of injury that are at least moderately common. It is not feasible to detect small changes (eg 10% year to year) even for common types of case. Non-sampling errors (especially from missed cases and data items) will be a threat to the validity of findings unless collection is managed closely and is consistent at all sites. A sufficiently good quality system is estimated to cost about $1 million per year to operate, and about $0.3 million to establish.

Successful implementation would require strong high-level support for the system to solve administrative and related issues that would arise when establishing a national, ongoing data collection program in emergency departments. Issues include confidentiality and privacy, data ownership and custody, and conditions of research access to data. The same system could also be used to sample ED attendances for other conditions, with potential to achieve gains in cost-efficiency by broadening the range of purposes served.

The second aspect cannot be achieved with existing data. The most important group of non-ED injury cases are those that receive medical attention. The BEACH* system could be used to learn more about the cases attending GPs, but no general solution to this issue is at hand.

Restriction of quantitative monitoring to relatively high-severity cases would improve feasibility in the short term. This need not involve ED-based data collection. Depending on the threshold chosen, all or nearly all of the cases monitored will be included in mortality and/or inpatient data collections. Certain enhancements to inpatient morbidity collection would improve its utility for this purpose.

Characterising:

This refers to description of specific types of injury case in terms of characteristics such as demographic and other features of the person injured, circumstances in which injury occurred, the way in which injury was sustained, objects and substances involved, and so on. It does not refer to monitoring incidence rates. Characterisation places less stringent demands on data quality than monitoring incidence mainly because strictly representative sampling is not essential.

Availability of a large pool of fairly detailed injury case records would enable characterisation of injury in terms of proportions, and would permit rapid and efficient identification and description of specific sub-groups of cases in which interest arises (eg cases involving a certain product). These simple analyses may lead directly to useful findings, or may raise hypotheses warranting further investigation.

The value of this approach follows from the many types of injury case that may be of interest and the cost, delay and difficulty of undertaking separate studies of particular case types as issues arise. There is potential to base case-control studies of injury risk factors on such data.

Important properties of a pool of cases for this purpose are the quality and completeness of case data, number of records, richness of case detail, recency of cases, and administrative arrangements that determine the uses to which data may be put. Strict representativeness, while desirable, is not essential for this purpose, and this type of system could build on existing injury data collection activity in EDs. A pool of, say, 200,000 records no more than 4 years old would be a national tool enabling characterisation of all but rare types of injury case (and uncommon types that have emerged recently). A smaller pool would have similar utility except for uncommon types of case.

Context:

Investment in emergency department data collection for either of these purposes is expensive, and should be weighed against other needs - for other types of information, intervention programs, etc. The *National Framework for Public Health Information* distinguishes four domains of information that are needed for effective public health practice: population health status; determinants of health; interventions; and infrastructure. ED-based injury surveillance contributes mainly to understanding health status and (depending how it is used) to assessing injury determinants.

For further information, contact James Harrison at RCIS, Tel: 08 8374 0970; E-mail: james.harrison@nisu.flinders.edu.au

* A sample survey of general practice activity, operated by the AIHW General Practice Statistics & Classification Unit at the University of Sydney.

Injury 2000—the latest conference news

Monitor 17 excitedly announced *Injury 2000: prevention and management*, the mega-meeting scheduled to take place in Canberra in November this year. We report here on the developments with the Injury component of this big event.

The Scientific Program

The theme for Fourth National Conference on Injury Prevention and Control (4NCIPC) is, *Injury prevention — everybody's business.* The following issues will form a major part of the Conference program:

- Safe Communities;
- Role of emergency services in injury prevention;
- High risk behaviour, self-harm, violence;
- Consumer safety;
- Appropriate use of data;
- Safety promotion and public perceptions;
- Injury prevention in Indigenous communities; and
- Road safety.
- Consumer Safety

The following people have been selected for membership of the Scientific Program Committee: Lesley Day, Jane Elkington, Richard Franklin, Beth Fuller, James Harrison, Jerry Moller, Rod McClure, Robyn Norton and Alison Sewell.

In keeping with the theme of the Conference, *Injury Prevention—everybody's business,* the Committee wants to use the first morning to set the scene for extending the injury prevention debate beyond the constraints frequently imposed by research and operational fields. Their aim is to push the boundaries to stimulate thinking about commonalties and ways of sharing expertise, experience, resources and time to improve the overall impact of injury prevention activities in this Country—and perhaps beyond its borders.

The Delegates

Consistent with diverse and multi-disciplinary nature of the injury community, delegates to the Conference will include practitioners, researchers, government policy makers, administrators, insurers, paramedics, rural practitioners, emergency nurses and rescue service personnel from both Australia and overseas. They'll represent fields such as: risk assessment; program design and implementation; injury research and epidemiology; biomechanics; primary prevention, including health promotion; occupational health and safety; acute care; rehabilitation; and social policy.

The Keynote speakers

An impressive line-up of keynote speakers has been arranged:

Professor John Campbell, Dean, Faculty of Medicine, University of Otago Medical School, New Zealand

Dr Adam Graycar, Director, Australian Institute of Criminology, Canberra, Australia

Associate Professor Cindy Shannon, Head, Indigenous Health Program, Queensland University.

Dr Ron Medford, Assistant Executive Director, Office of Hazard Identification and Reduction, United States Consumer Product Safety Commission, Washington DC, USA

Dr Michael Resnick, Professor of Pediatrics and Public Health, Division of General Pediatrics and Adolescent Health, USA.

To obtain any further information, contact the Conference organising firm, Intermedia, Tel: 07 3858 5492; Fax (07) 3858 5522; E-mail; injury2000@im.com.au

Third National Conference on Injury Prevention and Control

THE CHALLENGE OF INTEGRATION

Proceedings available

The proceedings of the 3rd National Conference on Injury Prevention and Control, held in May 1999, are now available. The volume incorporates approximately 80 peer-reviewed full papers, including 15 by invited guest speakers. This exciting collection of papers from across the field of Injury Prevention and Control, provides important contemporary insights into Road Safety, Work safety, Child Injury Prevention, Sport and Home injury Prevention, Injury Prevention Older Persons and Indigenous Communities and into the acute care and rehabilitation of the injuries sustained. As the largest single collection of reports of this kind, it will be a vital addition to the libraries of all those with an interest in the field.

Copies of the Proceedings are selling for AUD$65 (AUD$50 for AIPN members), including postage and handling within Australia. To obtain a copy of the order form, contact Intermedia Convention & Event Management, PO Box 1280, Milton QLD 4064, Australia, Fax: +61 7 3858 5510.

Injury News from Abroad

Second Hand Woes?

In November 1999, the US Consumer Product Safety Commission (CPSC) began a national campaign to alert the public to the presence of hazardous goods for sale in thrift shops. Earlier last year, CPSC had conducted a study that involved visits to 301 randomly selected thrift shops throughout the USA. That research suggested that 69% of outlets for second-hand goods were selling at least one hazardous product. The three most common products were children's jackets and sweatshirts with drawstrings presenting a strangulation hazard, hairdryers that do not protect against electrocution and cribs that do not meet current US Safety Standards. CPSC suggests that one source for hazardous products in thrift shops are the donation or sale of products that have been recalled (in the US the CPSC recalls 250-300 such products annually).

The CPSC campaign is two-pronged:

1 A commitment is being sought from thrift shops to stop selling hazardous products. To assist with this, a check-list for thrift stores and shoppers is being distributed to a national body that represents second hand dealers and to national organisations including the Salvos and Goodwill. The check list is also being distributed via state and local government.
2 CPSC is also encouraging US States to adopt model legislation that prohibits thrift stores from selling certain banned or recalled products.

For further information, see CPSC Press Release #00-018, dated 17 November 1999. The Press Release, which includes direct links to copies of the CPSC Research Study, Checklist, and model legislation, are available on the Internet: www.cpsc.gov/cpscpub/prerel/prerelnov99.html

This time Delhi ... next stop Montreal

(continued from page 1)

on Injury Prevention and Control will take place from 12-15 May 2002 in Montreal, the capital city of Canada's Province of Quebec.

The Conference theme is *Injuries, Suicide and Violence: Building Knowledge, Policies and Practices to promote a Safer World*. The main topics will be Road safety; Occupational safety; Prevention of suicide and violence; Home and institutional safety; Sport and leisure safety; Trauma care and rehabilitation; Urban Safety; Epidemiology, intervention and evaluation strategies; Armed conflicts; and Products safety.

To obtain information about the Montreal Conference, contact: 511, place d'Armes, Suite 600, Montréal, QC, Canada H2Y 2W7, Tel: (514) 848-1133; Toll Free: 1-877-213-8368; Fax: (514) 288-6469;E-mail: info@trauma2002.com

The Conference also has its own website: www.trauma2002.com

WA bans some laser pointers

Western Australia has introduced a ban on the sale of powerful hand held laser pointers. The ban applies to red diode laser pointers of Class 3 and above, and has been introduced because of the risk to eyesight when they are not properly used. Traders selling laser pointers in Western Australian must now have them laboratory tested and keep the test report to prove that the pointers they are selling are in the lower-power categories. Breaches can attract fines of up to $5000. Laser pointers must also carry a permanent label with a user warning and their strength rating. While the Ministry of Fair Trading is not currently conducting random sampling they do have the mechanisms to test laser pointers to determine labelling accuracy.

The ban was welcomed by the Injury Control Council of Western Australia (ICCWA) in its November 1999 newsletter.[1] ICCWA supports the ban on these products, but argues that, without retrospective regulations, education strategies to highlight dangerous use especially by children should be implemented.

Further information about the new regulations is available from the WA Ministry of Fair Trading, Tel: 08 9244 1299. Information regarding tests reports for laser pointers is available from the WA Health Department's Radiation Health Section: Tel: 08 9346 2260.

Editor's Note

The *Injury Issues Monitor* is the journal of the Research Centre for Injury Studies at the Flinders University of South Australia. The Centre incorporates the National Injury Surveillance Unit (NISU).

Letters to the Editor are welcome.
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Flinders University of South Australia

Australian Institute of Health & Welfare

Health and Aged Care

ISSN No 1039-4885
AIHW Cat. No. INJ24

NSW Inquiry into portable soccer goals

In *Monitor* 17 we reported that the US Consumer Product Safety Commission and the US soccer goal industry had developed a new safety standard to reduce the risk of soccer goal tip-over. The initiative was a response to at least 23 deaths and 38 serious injuries—since 1979 in the US—from soccer goals tipping over and crushing children who climb on them or hang from the crossbar.

Recently, New South Wales investigated the use of this equipment in the Australian context. In 1999 the NSW Minister for Fair Trading, the Hon. John Watkins, launched a product inquiry when he reported that he had asked the Department of Fair Trading's Products Safety Committee (PSC) to investigate safety issues surrounding portable soccer goals. The Inquiry into portable soccer goals—ie soccer goals that are designed to be temporary structures and to be transported (whether in one piece or after disassembly) required the Committee to consider whether such products should be banned, or if their use should be allowed only subject to specified conditions or restrictions. It also asked the Committee to consider whether portable soccer goals should be the subject of a recall order under Part 3 Division 3 of the Fair Trading Act. Submissions to the Inquiry closed on 13 August last year. In a subsequent report to the Minister, the PSC recommended that guidelines be developed to govern the safe use, storage and manufacture of these products.

The decision of the Minister that the Department of Fair Trading develop guidelines in preference to a product safety standard was based on the fact that, it appears, over 90% of portable soccer goals are non-commercial in their origin. A product safety standard can only apply to suppliers in trade or commerce. At the time of the Inquiry the PSC found only one commercial supplier in New South Wales—that supplier has since ceased to stock these items.

The *Guidelines*, which were circulated for comment, are now complete. In developing them, the DFT has adopted those aspects of the US and European safety standards for portable soccer goals that were considered to be of value in the Australian context. They have supplemented this with a section that deals particularly with the storage and maintenance of portable soccer goals. NSW WorkCover data had identified this as a priority concern based on the extreme age and state of disrepair of some of this equipment (eg rusting as the result of weather exposure, and the breaking of welded joints.

The Minister will launch the *Guidelines* on 12 April. They will be widely disseminated by the Department of Fair Trading which will distribute them via the Soccer Federation of NSW to all soccer clubs. The State's Departments of Education, Sports & Recreation, and Local Government have also agreed to assist with their promotion.

Further information is available from John Furbank, Manager of the Safety & Standards Branch of the NSW Department of Fair Trading, Tel: 02 9895 0700; E-mail: jfurbank@fairtrading.nsw.gov.au Regularly updated information about the activities of the NSW Department of Fair Trading is available at their Internet site: www.fairtrading.nsw.gov.au

Letter to the Editor

Sports Eye Guard Standards

Your article "Mandatory Product Standards" (*Monitor* 18) prompted me to write and share some concerns I have about an Australian Standard developed to cover sports eye guards.

I am involved in the prevention of childhood eye injuries in sport through Princess Margaret Hospital for Children, Perth (PMH). I have monitored childhood eye injuries over the 15 year period 1983-1998.[2] 10% of the childhood eye injuries are sports related. Of all these eye injuries at PMH, 10% end up with permanent visual disability, but with sports eye injuries the figure is 27%.

Since 1992 we have had an Australian Standard for Sports Eye Guards (AS4066). Unfortunately, its introduction has not been entirely effective in ensuring that consumers are guided in choosing the safest products. Parents attempting to buy eye guards which comply with that Standard are often met by confusion on the part of retailers who quote irrelevant standards such as AS2228 (1990) impact resistance; AS1337 (1992) Industrial Standards; or AS1336 (1997) Occupational Standards.

If I, or one of my fellow ophthalmologists, want to be able to guarantee that a particular eye guard meets the requirements of AS4066, we must purchase that product and send it to an independent optics and radiometry laboratory for assessment—at a cost to ourselves of $300. My Department has already followed this procedure with one product.

A request I made to the Hon Joe Hockey, the Commonwealth's Minister for Financial Services and Regulation, for a list of AS4066 compliant products was unsuccessful—I was advised by the Minister that no such list exists because producers/manufacturers are not required to register their products. The Projects Manager of Standards Australia confirmed that no such registrations exist. The only way in which consumers can currently be sure that an eye guard they purchase is Australian Standards compliant, is to personally have that product tested by the above procedure.

Compliance with Australian Standards—with the exception of the small number of mandatory ones—is voluntary. While this remains the case—and in the absence of information for the consumer and relevant professional groups about product compliance—the potential usefulness of the system is quite limited.

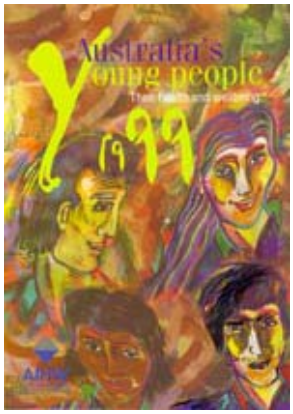
Parents are understandably anxious to protect their children and themselves from eye injuries during sport. The development and promotion of an Australian Standard for sports eye guards has not been successful in affording them this protection. Meanwhile children are being unnecessarily blinded. Over the two month period August-October 1999, there were 6 sporting eye injuries admitted to PMH. Our children have 70 years ahead of them—they deserve better than this.

Mary Bremner
Ophthalmologist
Princess Margaret Hospital for Children
Perth, WA

Dr Bremner can most readily be contacted at her private consulting rooms: 3 Ord Street, West Perth 6005, Tel: 08 9321 4594.

Something to read ... ?

Australia's Young People



Australia's Young People—Their Health and Wellbeing 1999 is the first national report on the health status of young people aged 12-24 years in Australia. Produced by the Australian Institute of Health & Welfare, It provides comprehensive information from currently available data sources, and is the second in a series of reports on child and youth health. This report includes information on important diseases and injuries, major risk factors and wider determinants of health. Separate sections are presented on the health status of particular priority groups: Aboriginal and Torres Strait Islander youth, young people living in rural and remote locations, young people born overseas and those from socioeconomically disadvantaged groups. This report will be relevant to anyone interested in youth health, including health planners and administrators, community and hospital practitioners, academic researchers, and the general public. All sections of this report can be downloaded, in *pdf* format, from the following Internet address: www.aihw.gov.au/publications/health.html Printed copies are available from Ausinfo for $35.00, Tel: 132 447 (toll free). AIHW Cat. No. PHE-19

Older Australia at a Glance

Now in its second edition, *Older Australia at a Glance* is a joint undertaking of the Australian Institute of Health and Welfare and the Office for Older Australians in the Commonwealth Department of Health and Aged Care. The original material contained in the first edition has been updated and further material added, to reflect the current health, wellbeing and social circumstances of older Australians and their health and welfare services. The report includes information and statistics on: life expectancies, health differentials, dependency levels and the nature of dependency, older people's organisations, formal and informal care for older Australians, retirement, income and housing as well as health and aged care services for older Australians. It takes into account the demography of older people, including Indigenous people and those from diverse linguistic and cultural backgrounds. Printed copies are available, for $15.00, from Ausinfo, Tel: 132 447 (toll free). AIHW Cat. No. AGE 12.

Acquired Brain Injury in Australia

In December 1999, the AIHW released *Definition, incidence and prevalence of acquired brain injury in Australia*. The report presents newly derived estimates of rates of hospitalisation associated with acquired brain injury, and the prevalence and demographic patterns of disability attributable to acquired brain injury in Australia. Definitions of acquired brain injury used in the disability and medical fields, and in legislative and administrative context are critically examined, and existing estimates of the incidence and prevalence of acquired brain injury, and of the proportion of incident cases that lead to long-term disability, are reviewed. Printed copies are available for $15.00 from Ausinfo, Tel: 132 447 (toll free). AIHW Cat. No DIS-15.

Diary

Note: where available, Internet address 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/

Meeting for Australasian Contributors to the Cochrane Collaboration
1-2 June 2000
Melbourne
Contact: Dimitria Semertjis, Australasian Cochrane Centre, Tel: +61 3 9594 7530; Fax: +61 3 9594 7554;
E-mail: cochrane@med.monash.edu.au
Website: www.cochrane.org.au

Vehicle Safety 2000
7-9 June 2000
London, United Kingdom
Contact: Jonathan Narbett C567 Conferences and Events Department, Institution of Mechanical Engineer, 1 Birdcage Walk, London SW1H 9JJ, England

2000 International Child Passenger Safety Technical Conference
10-14 June 2000
Arlington, USA
Contact: Kyran Quinlan, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control Centers for Disease Control and Prevention, E-mail: kaq0@cdc.gov
Website: www.cipsafe.org

Alcohol Policy XII Conference
11-14 June 2000
Washington DC, USA
Contact: Sheila Nesbitt, National Crime Prevention Council (USA),
E-mail: snesbitt@ncpc.org
Website: www.ncpc.org/alcoholpolicy/

11th Annual Conference of the Australasian Association for Quality in Health Care
15-16 June 2000
Darwin, Northern Territory
Contact: Quality Unit, Royal Darwin

Hospital; Tel: 08 8922 8215; Fax: 08 8922 8286; E-Mail: raj.verma@nt.gov.au
Webite: www.sci.usq.edu.au/aaqhc

Australia's Health Conference 2000
22 June 2000
Canberra, Australia
Contact: Greer Dixon, Conference Coordinator, AIHW, Tel: 02 6244 1031; Fax: 02 6244 1044;
E-mail: greer.dixon@aihw.gov.au
Website: www.aihw.gov.au

Australian Pacific Healthy Cities Conference
26-28 June 2000
Canberra
Contact: ConSec Conference Management, Tel: 02 6251 0675; Fax: 02 6251 0672; E-mail: consec@spirit.com.au
Website: www.healthycitiescanberra.org.au

Local Government Road Safety Conference
20-21 July 2000
Melbourne
Contact: Irene Thavarajah, Conference Organiser, Tel: 03 9905 1344; Fax: 03 9905 1343;
E-Mail: oce@adm.monash.edu.au

Reducing Criminality: Partnerships and Best Practice
31 July to 1 August 2000
Perth
Contact: Conference Coordinators, Tel: 02 6292 9000; Fax: 02 6292 9002; E-mail: conference@netinfo.com.au

6th Annual Conference on Health Outcomes
2-3 August 2000
Canberra
Contact: Jan Sansoni or Lorna Tilley, Australian Health Outcomes Collaboration, Tel: 02 6205 0869 or 6291 7271; Fax: 02 6291 2371 or 6205 2037;
E-mail: jan.sansoni@act.gov.au
or jansan@atrax.net.au
Website: www.health.act.gov.au/epidem/ahoc.html

World Federation of Public Health Association (WFPHA) 9th International Congress
2-6 September 2000
Beijing, China
Contact: WFPHA Secretariat, C/-American Public Health Association, 800 I Street Washington DC 20001-3710, USA; Tel: +1 202 777 2487; Fax: +1 202 777 2534

Australian & New Zealand Burn Association Annual Scientific Meeting
5-8 September 2000
Perth
Contact: Conference Secretariat, Tel: 08 9322 6662 or 9322 6906; Fax: 08 9322 1734
E-mail: conwes@congresswest.com.au
Website:www.congresswest.com.au/ANZBA2000/

3rd International PhD Course on Safety Promotion Research
16-27 October 2000
Stockholm, Sweden
Contact: Moa Sundstrom, Course Secretariat,
Karolinska Institute, Tel: +46 8 517 779 48; Fax: +46 8 33 46 93;
E-mail: moa.sundstrom@socmed.sll.se
Website: www.phs.ki.se/education/

8th International Cochrane Colloquium
25-30 October 2000
Cape Town, South Africa
Contact: Ms C Daries or Ms M Salomo, Conference Coordinators, 8th International Cochrane Colloquium, South African Medical Research Council, Tel: +27 21 938 0433/0202;
Fax: +27 21 938 0395/0418;
E-mail: charleen.daries@mrc.ac.za or mandy.salomo@mrc.ac.za
Website: www.mrc.ac.az/conference/cochrane.htm

12th National Health Promotion Conference
29 October to 1 November 2000
Melbourne
Contact: Conference Secretariat, Tel: 03 9682 0244; Fax: 03 9682 0288
E-Mail: health@icms.com.au
Website: www.icms.com.au/health

Women in Corrections: Staff and Clients
31 October to 1 November 2000
Adelaide
Contact: Conference Coordinators, Tel: 02 6292 9000; Fax: 02 6292 9002;
E-Mail: conference@netinfo.com.au

39th Annual Scientific Meeting of the International Medical Society of Paraplegia
2-5 November 2000
Sydney
Contact: IMSOP 2000, Tel: +61 2 9956 8333; Fax: +61 2 9956 5154;
E-mail: confact@conferenceaction.com.au

6th International Congress of Behavioral Medicine
15-18 November 2000
Brisbane
Contact: Congress Secretariat, Tel: 07 3369 0477; Fax: 07 3369 1512; E-Mail: icbm2000@im.com.au
Website: www.icbm2000.conf.au

Injury 2000: Prevention and Management
19-25 November 2000
Canberra
Contact: Intermedia Convention & Event Management, Tel: 07 3369 0477; Fax: 07 3369 1512;
E-mail: injury2000@im.com.au

Road Safety Research, Policing & Education Conference
26-28 November 2000
Brisbane
DEADLINE FOR ABSTRACTS: 1 July 2000.
Contact: Road Safety 2000 Secretariat, Tel: +61 7 3858 5554; Fax: +61 7 3858 5510 ;
E-mail: rs2000@im.com.au

10th International Conference on Safe Communities
21-23 May 2001
Anchorage, Alaska, USA
Contact: Diana Hudson, Tel: +1 907 929 3939; Fax: +1 907 929 3940;
E-mail: nhudson@alaska.net

1st WHO Safe Community Conference on Cost Calculation and Cost-effectiveness in Injury Prevention and Safety Promotion
30 September to 3 October 2001
Viborg County, Denmark
Contact: Viborg Amt, WHO Safety Community Conference 2001, Tel: +45 8660 2311; E-Mail: ukhkk@bibamt.dk
Website: www.vibamt.dk/conference2001

Footnotes

1 Injury Control Council of Western Australia, *Injury Prevention Newsletter*. Vol 3, Issue 4 November 1999.

2 Bremner MH. Childhood eye injuries, 1983 to 1993. Letter to the Editor. *Medical Journal of Australia*. Vol 170, 21 June 1999. p 620.