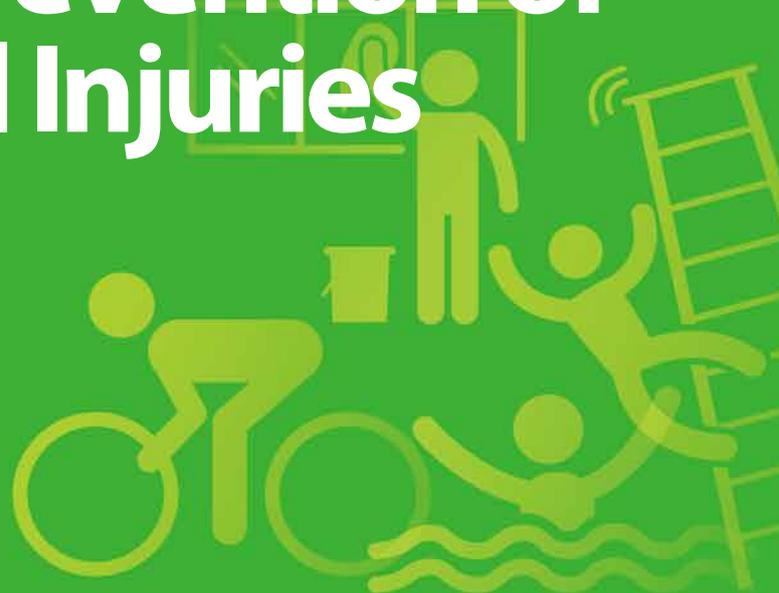




Action Plan to Strengthen Prevention of Unintentional Injuries in Hong Kong



Action Plan to Strengthen Prevention of Unintentional Injuries in Hong Kong



Department of Health
Hong Kong Special Administrative Region of China

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Abbreviations

| Abbreviation | Full name |
|--------------|---|
| ACLS | Advanced Cardiac Life Support |
| A&E | Accident and Emergency |
| AED | Accident and Emergency Department |
| AMS | Auxiliary Medical Service |
| AMSA | Asian Medical Students' Association |
| BLS | Basic Life Support |
| BRFS | Behavioural Risk Factor Survey |
| C&ED | Customs and Excise Department |
| CHEP | Centre for Health Education and Health Promotion |
| CHEU | Central Health Education Unit |
| CHS | Child Health Survey |
| CIPRA | Childhood Injury Prevention and Research Association |
| CISS | Community Injury Surveillance System |
| DALYs | Disability-Adjusted Life Years |
| DH | Department of Health |
| EDB | Education Bureau |
| EHCs | Elderly Health Centres |
| EHS | Elderly Health Service |
| FHB | Food and Health Bureau |
| FHS | Family Health Service |
| HA | Hospital Authority |
| HCPF | Health Care and Promotion Fund |
| HHSRF | Health and Health Services Research Fund |
| HKMA | Hong Kong Medical Association |
| HKPF | Hong Kong Police Force |
| HMRF | Health and Medical Research Fund |
| ICECI | International Classification of External Causes of Injury |
| ICHDP | Integrated Child Health and Development Programme |
| LCSD | Leisure and Cultural Services Department |
| LD | Labour Department |
| MCHCs | Maternal and Child Health Centres |
| NCD | Non-communicable Diseases |
| NGOs | Non-governmental Organisations |
| OSHC | Occupational Safety and Health Council |
| PCO | Primary Care Office |
| PHS | Population Health Survey |
| PMH | Princess Margaret Hospital |
| PYLL | Potential Years of Life Lost |
| RCHEs | Residential Care Homes for the Elderly |
| SC | Steering Committee on Prevention and Control of Non-communicable Diseases |
| SFH | Secretary for Food and Health |
| SHS | Student Health Service |
| SHSCs | Student Health Service Centres |
| US | United States |
| WGAH | Working Group on Alcohol and Health |
| WGDPA | Working Group on Diet and Physical Activity |
| WGI | Working Group on Injuries |
| WHO | World Health Organization |

Preface

Injuries are a global public health problem. According to the World Health Organization (WHO), about 5.8 million people die each year as a result of injuries, and many non-fatal injuries result in life-long disabilities and suffering. As such, injury prevention is accorded high priority by WHO and many countries.

In Hong Kong, injuries have remained one of the leading causes of death since the 1960s. In 2013, injuries ranked fifth among the leading causes of death and accounted for 1 860 deaths. Injuries could lead to premature death and disability. The impact of injuries on individuals, families and society should not be underestimated.

Traditionally, unintentional injuries have been regarded as random, unavoidable “accidents”. During the last few decades, however, a better understanding of the nature of injuries changed these old beliefs. Today, unintentional injuries are viewed as largely preventable events through better understanding of their risk factors and reduction of their likelihood and severity.

In line with Government’s strategic framework document *“Promoting Health in Hong Kong: A Strategy Framework for Prevention and Control of Non-communicable Diseases”* published in 2008, the Working Group on Injuries (WGI) was set up in 2012 to advise on priority actions for health improvement in the area of injury prevention, and to make recommendations on the development, implementation and evaluation of an action plan for the prevention of injuries.



Four meetings of the WGI were held to examine, among other things, overseas evidence and local situation, before drawing up this Action Plan to outline the direction and steps to take in the years ahead for effective prevention of injuries in Hong Kong. As Chairman of the WGI, I would like to thank all members of the working group and others who have contributed to development of this Action Plan.

Every individual and organisation has a role to play in the prevention of injuries. I take this opportunity to appeal for concerted efforts from stakeholders across sectors in this important endeavour. I am confident that in partnership, we can build a healthier and safer place to live.

Patrick MA Ching-hang, BBS, JP
Chairman
Working Group on Injuries



1

Introduction





1. Introduction

Developing a local strategy to strengthen the prevention of unintentional injuries

- 1.1 The number of people suffering from non-communicable diseases (NCD) is increasing, both worldwide and in Hong Kong. To combat NCD, the Department of Health (DH) published a strategic framework document entitled *“Promoting Health in Hong Kong: A Strategic Framework for Prevention and Control of Non-communicable Diseases”* in October 2008, which provided an armory of overarching principles for the prevention and control of NCD.
- 1.2 To oversee the implementation of the strategic framework, a high-level Steering Committee on Prevention and Control of NCD (SC) was established in late 2008. The SC is chaired by the Secretary for Food and Health (SFH), with members from Government, public and private sectors, academia and professional bodies, industry and other key partners. The SC endorsed the setting up of working groups to assess and address behavioural NCD risk factors of public health significance.
- 1.3 The Working Group on Diet and Physical Activity (WGDPA) was established on 16 December 2008 to tackle imminent problems caused by unhealthy dietary habits, physical inactivity and obesity. The *“Action Plan to Promote Healthy Diet and Physical Activity Participation in Hong Kong”* was launched in 2010.
- 1.4 The Working Group on Alcohol and Health (WGAH) was established on 23 June 2009 to look into problems related to alcohol misuse. The *“Action Plan to Reduce Alcohol-related Harm in Hong Kong”* was launched in 2011.



- 1.5 As injury prevention merits special attention, the Working Group on Injuries (WGI) was established on 6 February 2012 to advise on the priority areas for action and to draw up targets and action plans related to injury prevention. The WGI is chaired by Mr Patrick MA Ching-hang and comprises stakeholders from the public and private sectors, representatives from the academia, District Councils, education sector, healthcare professionals, social services sector and relevant government departments. The membership and the terms of reference of the WGI are listed in Annexes 1 and 2 respectively.
- 1.6 Since its establishment in February 2012, WGI has met four times to discuss:
- i. Global development of injury prevention and local situation of injuries;
 - ii. Priority areas to strengthen injury prevention in Hong Kong;
 - iii. Recommendations to strengthen injury prevention; and
 - iv. Action Plan to strengthen injury prevention.
- The topics discussed in the meetings are listed in Annex 3.
- 1.7 After careful consideration of the available evidence and the local situation, the WGI produced an *“Action Plan to Strengthen Prevention of Unintentional Injuries in Hong Kong”*, highlighting five strategic directions and nine recommendations to strengthen injury prevention in Hong Kong. The Action Plan was endorsed by the SC in September 2014. To implement the nine recommendations therein, the WGI proposed 16 specific actions which are set out in detail in Chapter 3 of this document.

Definition and classification of injuries

- 1.8 The World Health Organization (WHO) defines injuries as the physical damage that results when a human body is suddenly or briefly subjected to intolerable levels of energy. It can be a bodily lesion resulting from acute exposure to energy in amounts that exceed the threshold of physiological tolerance, or it can be an impairment of function resulting from a lack of one or more vital elements (i.e. air, water, warmth), as in drowning, strangulation, or freezing^{1,2}.
- 1.9 Injuries can be divided into intentional injuries and unintentional injuries. The WHO defines intentional injuries as injuries that are purposely inflicted, either by the victims themselves (i.e. suicide and suicide attempts) or by other persons (i.e. homicide, assault, rape, child abuse, elderly abuse, and family violence), and unintentional injuries as injuries that are not intentionally inflicted (i.e. road traffic injuries, fall injuries, sport injuries, occupational injuries, child poisoning, burns and drowning).²
- 1.10 To avoid overlapping of important injury topics already receiving attention from relevant authorities, the Working Group, after deliberation, has decided that the scope of this *“Action Plan to Strengthen Prevention of Unintentional Injuries in Hong Kong”* should be confined to unintentional injuries.

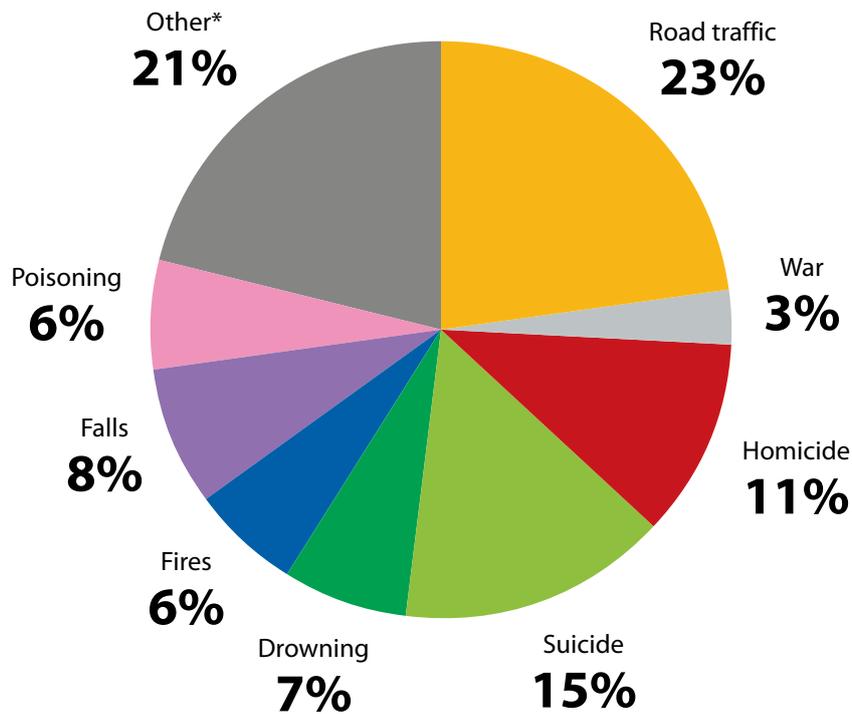
¹ *Injuries and Violence: The Facts*. WHO. 2010

² World Health Organization (2010). *TEACH-VIP E-Learning – Foundations and methods*. Available at: <http://teach-vip.edc.org/documents/lpGp/InjuryPreventionGeneralPrinciples.pdf>, accessed 23 April 2014

Global disease burden from injuries

1.11 Injuries and violence are among the most prominent public health problems in the world. Every year, intentional and unintentional injuries cause a significant number of deaths, human sufferings and disabilities, both globally and locally. Worldwide, injuries account for 5.8 million deaths each year, comprising 10% of all deaths.¹ This equates to almost 15 000 injury deaths per day. The top leading cause of death globally from injuries is road traffic accident. Road traffic injuries alone are predicted to increase in importance and become the fifth leading cause of death in 2030 (Figure 1 and Table 1).¹

Figure 1: Causes of injury deaths worldwide in 2004



* "Other" includes smothering, asphyxiation, choking, animal and venomous bites, hypothermia and hyperthermia, as well as natural disasters.

Source: *Global burden of disease*. World Health Organization. 2004

Table 1: Leading causes of deaths in 2004 and 2030 (predicted) worldwide

| Total 2004 | Total 2030 |
|--|--|
| 1. Ischemic heart disease | 1. Ischemic heart disease |
| 2. Cerebrovascular disease | 2. Cerebrovascular disease |
| 3. Lower respiratory infections | 3. Chronic obstructive pulmonary disease |
| 4. Chronic obstructive pulmonary disease | 4. Lower respiratory infections |
| 5. Diarrhoeal diseases | 5. Road traffic crashes |
| 6. HIV/AIDS | 6. Trachea, bronchus, lung cancers |
| 7. Tuberculosis | 7. Diabetes mellitus |
| 8. Trachea, bronchus, lung cancers | 8. Hypertensive heart disease |
| 9. Road traffic crashes | 9. Stomach cancer |
| 10. Prematurity and low birth weight | 10. HIV/AIDS |
| 11. Neonatal infections and other | 11. Nephritis and nephrosis |
| 12. Diabetes mellitus | 12. Suicide |
| 13. Malaria | 13. Liver cancer |
| 14. Hypertensive heart disease | 14. Colon and rectum cancers |
| 15. Birth asphyxia and birth trauma | 15. Oesophageal cancer |
| 16. Suicide | 16. Homicide |
| 17. Stomach cancer | 17. Alzheimer and other dementias |
| 18. Cirrhosis of the liver | 18. Cirrhosis of the liver |
| 19. Nephritis and nephrosis | 19. Breast cancer |
| 20. Colon and rectum cancers | 20. Tuberculosis |

Source: *World health statistics 2008* (www.who.int/whosis/whostat/2008/en/index.html)

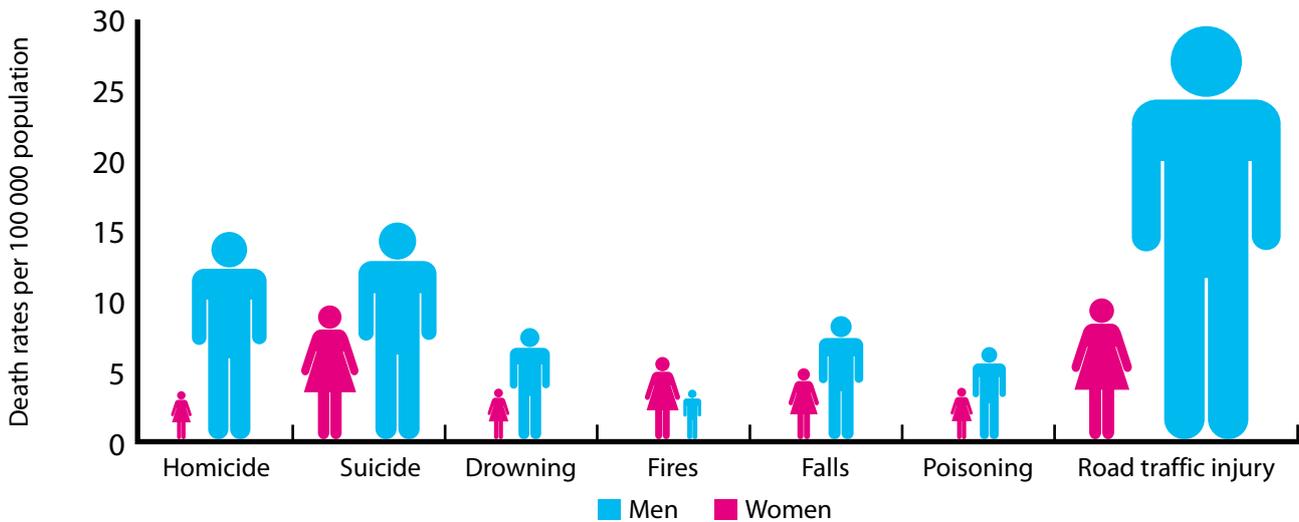
1.12 Injuries and violence are significant causes of death and ill health in all countries, but they are not evenly distributed around the world or within countries, and some people are more vulnerable than others.¹

1.13 More than 90% of deaths that result from injuries occur in low- and middle-income countries. Injury death rates are 2.5 times higher in poorer European countries than in wealthier ones.¹

1.14 Injuries are a leading cause of death among young people. Among people between the ages of 5 and 44 years, injuries are one of the top three causes of death.¹ Road traffic injuries are the leading cause of death among those aged between 15 and 29 years, with homicide and suicide the fourth and fifth leading causes of death respectively among this group.¹ Among the elderly, falls are the most common cause of injury death.¹

1.15 Twice as many men as women die each year as a result of injuries. The three leading causes of death from injuries for men are road traffic injuries, suicide and homicide, while leading causes for women are road traffic injuries, suicide, and fire-related burns (Figure 2).¹

Figure 2: Death rates per 100 000 population, by different causes of injury and sex, World, 2004

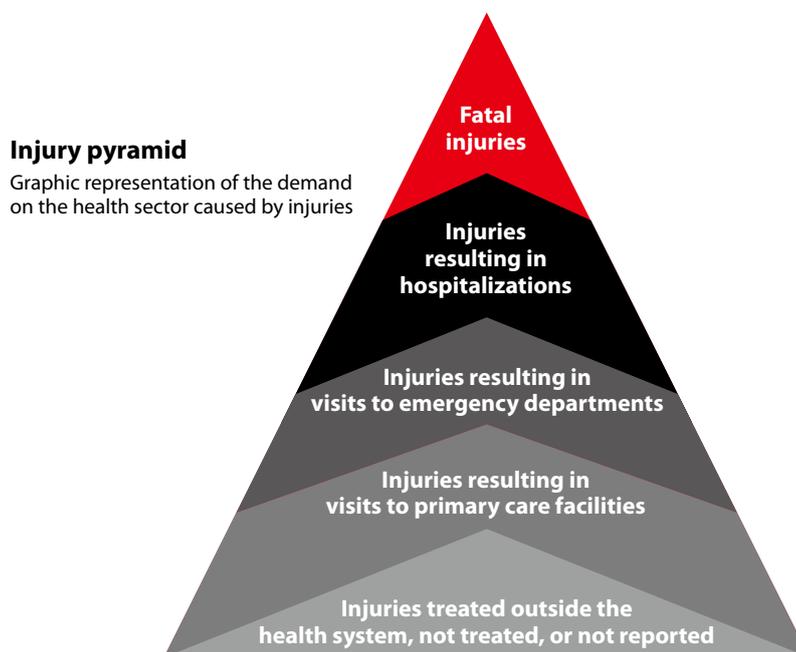


Source: *Global burden of disease*. World Health Organization. 2004

1.16 For every death from injury there are many more injuries that result in hospitalisation, treatment in emergency departments, or treatment by practitioners outside the formal health sector. According to a study published by WHO, in the world’s high-income countries such as the Netherlands, Sweden and the United States (US), for every person killed by injury, approximately 30 times as many people are hospitalised and roughly 300 times as many are treated in hospital emergency rooms and then released.³ In terms of the number of people being affected, deaths constitute only a small part of the total injury toll. In fact, for every victim killed by injury, many more are seriously and permanently disabled and many more again suffer minor, short-term disabilities.⁴ The mortality and morbidity of injury events can best be represented by an injury pyramid. Fatal injuries usually represent the tip of the pyramid, which means they are relatively rare. Midway down the pyramid are injuries resulting in hospitalisations, medical attention at emergency care units or outpatient clinics, and further down are injuries which do not result in medical treatment but may nevertheless cause leave absences and productivity loss.

³ CDC (2005). *CDC Injury Surveillance Training Manual Participant Guide 2005*. Available at: <http://stacks.cdc.gov/view/cdc/11390>, accessed 23 April 2014
⁴ Holder Y, Peden M, Krug E et al (Eds). *Injury surveillance guidelines*. Geneva, WHO. 2001

Figure 3: Graphic representation of the demand on the health sector caused by injuries



Source: *Injuries and Violence: The Facts*. World Health Organization. 2010.

1.17 Many of the injured will be left with disabling consequences, and in some cases, permanent ones.⁵ When disability resulted from injuries is also taken into consideration, injuries represent an even more significant public health problem, especially in light of the fact that injuries affect mainly young people, that is to say, the economically most productive sector of the population. Injuries can have an impact at personal as well as household levels, particularly when the injured person is the breadwinner.

1.18 Globally, injuries account for 10.4%⁶ of all disability-adjusted life years (DALYs), and this is expected to increase to 20.1%⁷ by 2020. Besides huge physical and mental harm that injuries and violence produce on those affected, considerable economic losses are caused to victims, their families, and to nations as a whole, including productivity losses due to injury death and disability, combined with the costs of treatment and rehabilitation of the injured. The economic cost of road traffic crashes globally has been estimated at US\$518 billion and cost most countries between 1-2% of their gross national product.¹

⁵ Fazlur Rahman AKM. *A model for injury surveillance at the local level in Bangladesh: implications for low-income countries*. Stockholm, Karolinska Institute, 2000.

⁶ World Health Organization. 2011. *Health statistics and health information systems*. http://www.who.int/healthinfo/global_burden_disease/estimates_country/en/index.html, accessed 30 December 2011.

⁷ Murray CJL, Lopez AD. *Alternative projections of mortality and disability by cause 1990–2020: Global Burden of Disease Study*. *Lancet*, 1997, 349:1498–1504.

1.19 Injuries and violence have not made their way into the global health agenda for a long time despite their being predictable and largely preventable. It is now believed that many injuries and much violence can be prevented. There is a broad range of strategies based on sound scientific evidence shown to be effective in reducing injuries and violence, and these strategies need to be more widely adopted. Decline in injuries has been observed mainly in high-income countries due largely to application of these effective prevention and treatment strategies through concerted efforts that involve, but are not limited to, the health sector. The international community needs to work with governments and non-governmental organisations (NGOs) around the world to implement these proven measures and reduce the unnecessary loss of life that occurs each day as a result of injuries and violence. Action must be taken now to decrease the adverse impact caused by injuries in our community.¹

Global actions

1.20 In 1996, the Forty-ninth World Health Assembly adopted Resolution 49.25. The Resolution declared violence a leading global public health problem. In response to the Organization's increasing commitment to address injuries and violence, the WHO's Department of Violence and Injury Prevention and Disability (VIP) was established in March 2000. It acts as a facilitating authority for international science-based efforts to promote safety and prevent violence and unintentional injuries, to mitigate their consequences, and to enhance the quality of life for persons with disabilities irrespective of the causes.^{8,9}

1.21 The *World report on violence and health* was released in October 2002. It was the first most visible product of VIP. As a result of the Resolution WHA 56.24 on Implementing the Recommendations of the *World Report on Violence and Health* (2003), many Member States have started to develop national reports, plans of action, networks and other activities stemming from the Report and designed to prevent violence. Two guiding documents *Developing policies to prevent injuries and violence: guidelines for policy-makers and planners* and *Preventing injuries and violence: a guide for ministries of health* were released in 2006 and 2007 respectively to describe the necessary steps for creating an injury and violence prevention policy. The WHO Western Pacific Region also released a guiding document *Regional Framework for Action on Injury and Violence Prevention 2008-2013 Strengthening Injury and Violence Prevention in the Western Pacific Region* to assist countries in defining and preventing avoidable deaths and disability from these causes.

⁸ World Health Organization. 2011. *Violence and Injury Prevention and Disability (VIP)*. Available at: http://www.who.int/violence_injury_prevention/about/en/index.html, accessed 24 April 2014

⁹ World Health Organization. 2002. *Department of Injuries and Violence Prevention Annual Report 2002*

- 1.22 In recent years, WHO has significantly stepped up its activities in the area of injury and violence prevention. The Organization's *World report on child injury prevention*, *World report on road traffic injury prevention* and *World report on violence and health* and the resolutions related to these reports passed by the World Health Assembly and the WHO Regional Committees specifically call upon governments to identify focal points for injury and violence prevention within Ministries of Health to coordinate and facilitate national efforts.
- 1.23 In 2010, General Assembly of the United Nations proclaimed 2011–2020 the Decade of Action for road safety, with a global goal of stabilising and then reducing the forecasted level of global road fatalities by increasing activities conducted at national, regional and global levels. The United Nations Road Safety Collaboration has developed the *Global Plan for the Decade of Action for Road Safety 2011-2020*¹⁰ as a guiding document to support the implementation of its objectives.
- 1.24 Many governments around the world have developed national injury prevention policies, strategies and/or plans of action. Although these instruments vary in nature and scope, they serve to guide a nation's efforts to prevent injury-related death and disability. Of these national injury prevention policies, strategies and/or plans, some are comprehensive pertaining to all injury-related mortality and morbidity, while others focus on a particular type of injuries such as road traffic injuries or violence-related injuries or a particular group of intended beneficiaries such as children, youth or women. Much depends on the burden posed by these public health concerns and the government's preparedness and ability to recognise these as issues to be addressed.
- 1.25 Increasing awareness in the last few decades that injuries and violence are preventable public health problems has led to the development of preventive strategies. There were already many scientifically-proven measures to reduce key causes of injury-related deaths. In the light of accumulating evidence, evidence-based and effective interventions for injury prevention may be considered for adoption locally.
- 1.26 The ultimate goal is to prevent injuries and violence from happening in the first place. At the same time, much can be done to minimise disability and ill-health arising from injury events that do occur. Providing quality support and care services to victims of violence and injuries can prevent fatalities, reduce the amount of short-term and long-term disabilities, and help those affected to cope with the impact of the violence or injuries on their lives. Improving the organisation, planning and access to trauma care systems, including pre-hospital and hospital-based care, can help reduce the effects of injuries.

¹⁰ United Nation Road Safety Collaboration. 2011. *Global Plan for the Decade of Action for Road Safety 2011-2020*. Available at: http://www.who.int/roadsafety/decade_of_action/plan/en/#, accessed 25 June 2014



2

Injury prevention: Hong Kong situation



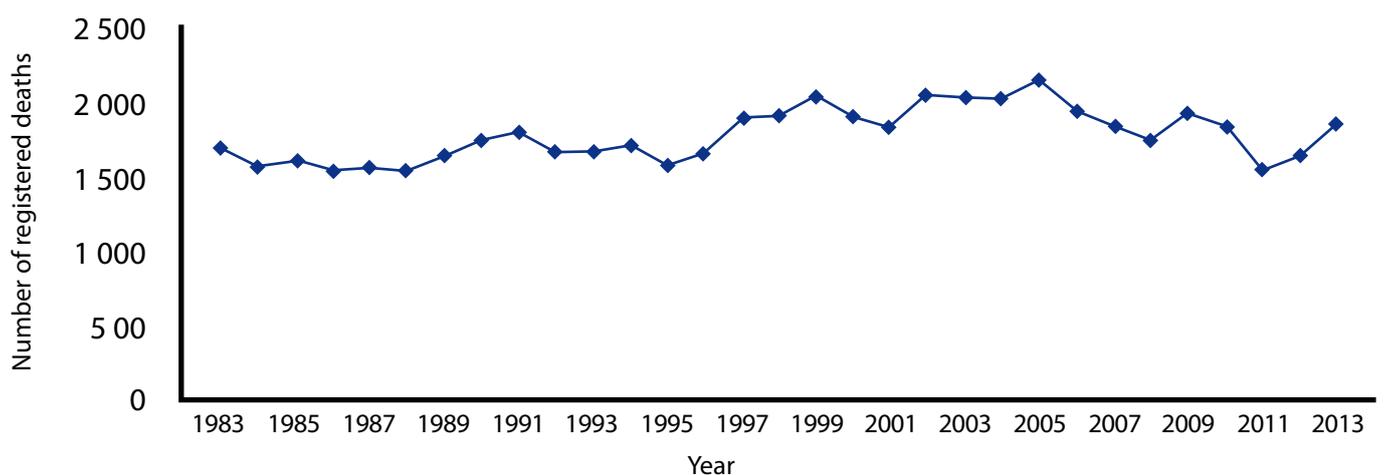


2. Injury prevention: Hong Kong situation

Epidemiology of injuries and disease burden

2.1 During the years 1983-2013, the number of registered deaths in Hong Kong due to injuries ranged from 1 551 to 2 243 per year (Figure 4). In 2013, 1 860 registered deaths were caused by injuries, accounting for 4.3% of total deaths. Injuries were the fifth leading cause of death. The death rates due to injuries for male and female were 36.1 and 17.1 per 100 000 population, respectively. In the age group 1-14 years, injuries were the second leading cause of death in 2013. It remained in the second place consistently in the past ten years, with exceptions in 2009 and 2010. In these two years, injuries were the leading cause of death in this age group (1-14 years).

Figure 4: Number of registered deaths in Hong Kong due to injuries, 1983-2013

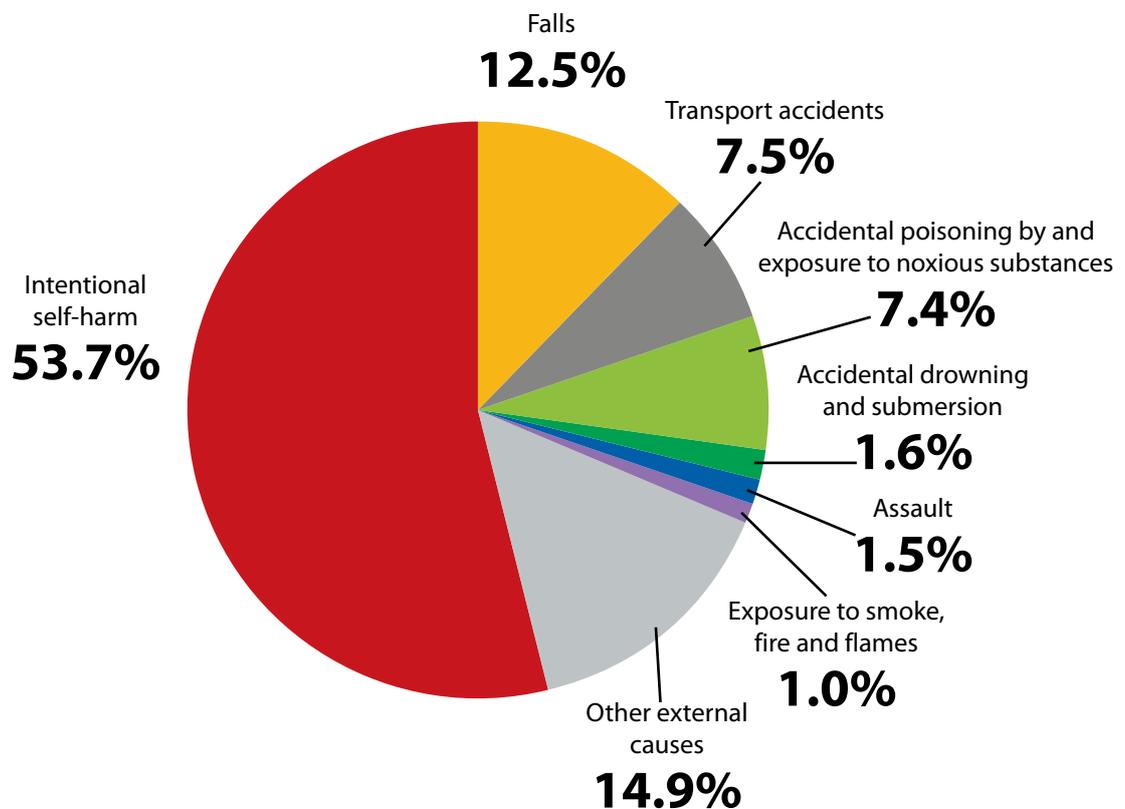


Source: Department of Health



2.2 Among the 1 860 registered deaths related to injuries in 2013 (Figure 5), the causes of death in descending order were intentional self-harm (999 or 53.7%), falls (232 or 12.5%), transport accidents (140 or 7.5%), accidental poisoning by and exposure to noxious substances (137 or 7.4%), accidental drowning and submersion (30 or 1.6%), assault (27 or 1.5%), exposure to smoke, fire and flames (18 or 1.0%) and other external causes (277 or 14.9%).

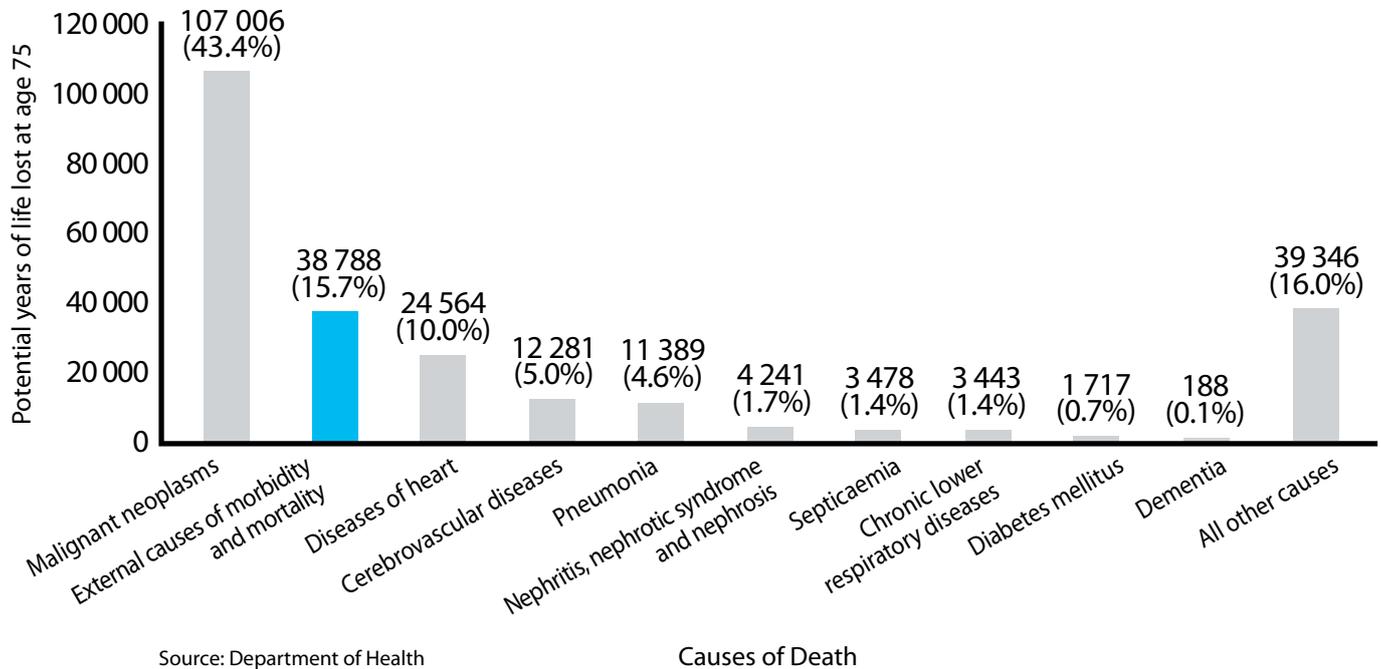
Figure 5: Injury mortality by causes of death, 2013 (N=1 860)



Source: Department of Health

2.3 Despite the fact that injuries ranked only the fifth among leading causes of death in 2013, potential years of life lost (PYLL) attributable to injuries, that is, external causes of morbidity and mortality, ranked second among all causes of death (Figure 6). This is to say, injuries impose a heavy burden on premature mortality. The PYLL at age 75 caused by injuries accounted for 15.7% of the total in 2013. It ranked second after the leading cause cancer (43.4% of the total) and was followed by heart diseases (10.0%), cerebrovascular diseases (5.0%).

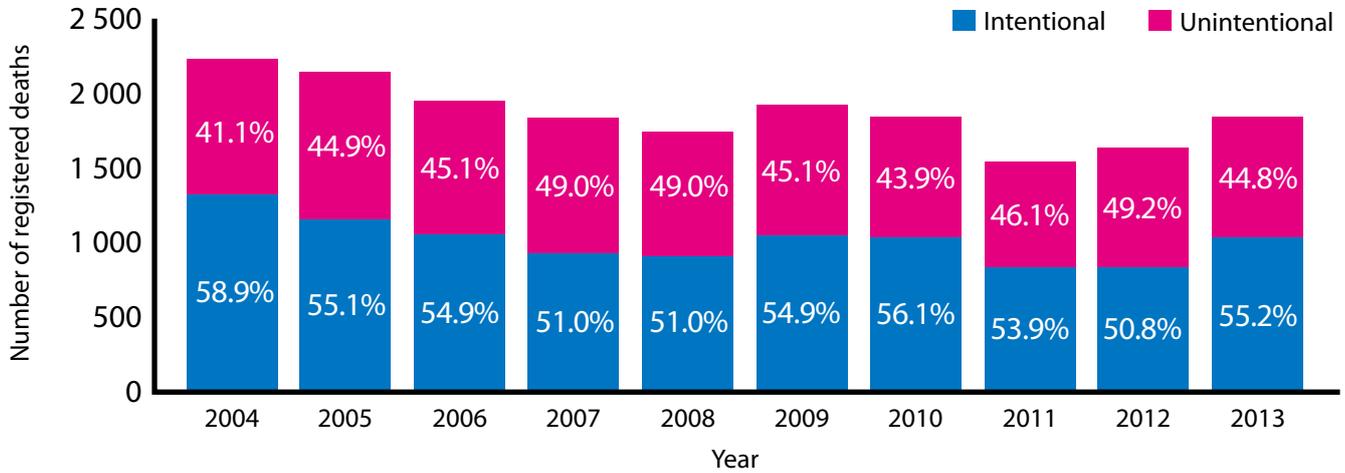
Figure 6: Potential years of life lost at age 75 by ten leading causes of death in Hong Kong, 2013



2.4 Regarding morbidity, among all in-patient discharges and deaths in all hospitals in 2013, 97 837 episodes were due to injuries. Injuries accounted for 5.1% of total in-patient discharges and deaths in that year. Among these 97 837 episodes of injury-related in-patient discharges and deaths, falls accounted for the largest share (39 450 episodes or 40.3%), followed by accidental exposure to other and unspecified factors (25 643 episodes or 26.2%) and exposure to inanimate mechanical forces (7 627 episodes or 7.8%).

2.5 Among all deaths due to injuries, the proportion of deaths caused by intentional injuries (i.e. injuries that are purposely inflicted either by victims themselves or other persons) remained relatively stable during the past decade (Figure 7). In 2013, 55.2% of the total number of deaths caused by injuries were intentional in nature.¹¹

¹¹ Public Health Information System, Surveillance and Epidemiology Branch, Centre for Health Protection, Department of Health, Government of Hong Kong SAR.

Figure 7: Number of intentional and unintentional injury deaths, 2004 - 2013

Source: Department of Health

- 2.6 Apart from collecting mortality and hospitalisation statistics, DH had also conducted a territory-wide household survey, the Injury Survey, in 2008 to collect pertinent information on the characteristics and burden of unintentional injuries in Hong Kong. 6.2% of the Hong Kong population reported to have sustained at least one unintentional injury that limited their normal activities in the 12 months before enumeration. The rate was similar in both gender groups and was found to be highest for elderly people aged 75 and above (8.9%).¹²
- 2.7 According to the *Injury Survey 2008*, the three commonest causes of injury episodes were falls (32.2%), sprain (25.8%) and sports (14.1%). Falls were found to have occurred more commonly in females and at the extremes of age (aged 0-14 and 55 and above). Over 80% of injury episodes affected the extremities.¹²
- 2.8 The Population Health Survey (PHS), another territory-wide household survey conducted in 2003-2004, showed that 14.3% of people aged 15 and above reported that they had sustained an injury that was serious enough to limit their normal activities in the 12 months preceding the survey.¹³ A significantly greater proportion of males (17.4%) than females (11.7%) reported so.¹³ The difference between this Survey and *Injury Survey 2008* is explained by the different case definition in these two surveys. In the *PHS (2003/2004)*, all injuries that were serious enough to limit one's normal activities were included, regardless of being intentional or unintentional. In *Injury Survey 2008*, only unintentional injuries that were serious enough to limit one's normal activities were included.

¹² Department of Health (2010). *Injury Survey 2008*

¹³ Department of Health (2005). *Population Health Survey 2003/2004*

2.9 According to the *Injury Survey 2008*, the average cost of the total medical expenses incurred in each injury episode was HK\$1 929.0 (median HK\$300). The total cost incurred as a result of injuries was estimated at HK\$838.6 million (95% CI HK\$473.9 million to HK\$1 203.4 million) in 2008. The cost increased with age and was the highest in persons aged 65 and above. More than half of the injury episodes (51.3%) sustained by employed persons caused them to be absent from work temporarily for an average of 19.8 days (median 7.0 days). The mean and median numbers of paid sick leaves taken were 13.5 and 5.0 days, respectively. The mean and median numbers of unpaid sick leaves taken were 29.6 and 7.0 days, respectively. 36.2% of the injury episodes caused the victims to change their normal daily activities and 1.4% caused them to develop residual disabilities for 6 months or longer. 17.1% of the injury episodes sustained by students caused the victims to take days off from school temporarily for an average of 11.5 days (median 3.0 days).¹²

Injury surveillance effort and information gap

2.10 An effective surveillance system for injuries can help provide useful information to assess the health needs of the population and monitor potential impacts of public health interventions. For mortality data, a death registration system managed by Immigration Department is in place to register and collect information related to deaths. This system gathers deaths reportable to the Coroner and those that are non-reportable. The Coroners Ordinance sets out 20 categories of death which should be reported to the Coroner. Death caused by an accident or injury is one of these 20 categories. As for morbidity data, the Government collects in-patient discharge statistics from all public, private and correctional institution hospitals.

2.11 To fill information gaps currently not covered by mortality and morbidity data, community surveys can serve as popular tools. The DH has conducted several community surveys to collect local information on injury for different age groups. The *PHS (2003/2004)* and the regular Behavioural Risk Factor Survey (BRFS) obtained some epidemiological information on injuries for subjects aged 15 and over and adults aged 18-64, respectively. The *Injury Survey 2008* was conducted based on the WHO Injury Surveillance Guidelines to collect pertinent information about the local characteristics and burden of unintentional injuries of all ages. The Child Health Survey (CHS) conducted in 2005 also collected data on common types of injuries in children, as well as injury prevention behaviours. In addition, some NGOs and academia* also conducted a number of relevant community surveys.

* Examples include the Hong Kong Childhood Injury Prevention and Research Association (CIPRA) and The Hong Kong Polytechnic University

- 2.12 In 2003, an Injury Surveillance System was set up in the Accident and Emergency Department (AED) of Princess Margaret Hospital. The program was funded by the Occupational Safety and Health Council (OSHC) and collaborated with The Hong Kong Polytechnic University. Under this surveillance system, details of all injury-related cases were recorded. Since then, the surveillance system has been extended to two more hospitals (Caritas Medical Centre and Tseung Kwan O Hospital). This Injury Surveillance System enabled researchers to identify injury black-spots and design preventive measures to reduce injury occurrence in community settings.
- 2.13 From available data, we have a good understanding on the pattern and burden of the major types of injuries. However, systematic collation and analysis of data is still lacking in a number of areas such as the prevalence of sports injuries, injury episodes that require medical care in the AED and injury episodes that are not severe enough to require hospitalisation. Besides, only limited information is available on attitude and barriers of the population towards adopting particular injury prevention measures.

Interventions to promote prevention of unintentional injuries

Raising public awareness to injury prevention

- 2.14 Injuries cause significant morbidity and mortality that warrants our attention. In Hong Kong, the Government and different health advocates have taken the initiative to implement a variety of interventions striving to provide a safe environment for the general public to live, study, work and play. Education is of paramount importance to increase public literacy and influence their attitudes, beliefs and behaviours towards injury prevention.
- 2.15 Various publicity campaigns have been conducted with support from the Information Services Department by different policy bureaux and departments to arouse public awareness of safety and injury prevention. Examples of these campaigns include promotion of road safety, occupational safety, against child neglect and abuse, etc. Most of these campaigns are sustained throughout the year and some of them are long standing promotion, and employ a variety of publicity and advertising means including information leaflets, media interviews, media campaigns, public workshops, exhibitions, community involvement activities and counseling. Some examples of media campaigns include "If you drink, don't drive!" and "Let's enhance household fire safety".

Encouraging research on injury prevention

2.16 The Government established several health-related funds to encourage health promotion good practices and local research to inform health policy formulation. The Health Care and Promotion Fund (HCPF) was established in 1995 with the aim of improving effectiveness of health promotion and disease prevention actions. A number of injury-related interventions have been subsidised by the fund. On the other hand, the Health and Health Services Research Fund (HHSRF) was established in 2002 to facilitate the generation of new knowledge in areas of human health and health services to improve health of the local community. The fund was managed by a Research Council chaired by SFH, which determined the research agenda and funding control mechanism. Research on injuries and poisoning was made as one of the thematic priorities. As announced in the 2011-2012 Budget Speech, the HHSRF (together with its funding ambit) subsumed under the new "Health and Medical Research Fund (HMRF)" which continues to provide a clear, focused research agenda for public health topics including injury prevention.

Interventions to promote injury prevention by the Department of Health

2.17 The DH has committed to safeguarding the health of the community through promotive, preventive, curative and rehabilitative services. Injury prevention has been promoted by the DH to the general public through various channels. The following paragraphs summarise these activities.

2.18 The Non-Communicable Disease Division of the Surveillance and Epidemiology Branch of Centre for Health Protection is responsible for surveillance and control of NCD of public importance to Hong Kong and formulation of strategies in relation to NCD prevention. Through conducting health surveys, for example Injury Survey, PHS and BRFSS, the Division regularly collects, collates, analyses and disseminates surveillance data on injuries. The information collected is useful for formulating injury prevention strategies; planning, implementing and evaluating health promotion programmes; organising injury prevention and control actions; and conducting risk communication activities through the electronic publication "*NCD Watch*" and the "*Change For Health*" website.

- 2.19 Through a network of 31 Maternal and Child Health Centres (MCHCs), the Family Health Service (FHS) provides a comprehensive range of health promotion and disease prevention services for children from birth to 5 years of age through the Integrated Child Health and Development Programme (ICHDP). ICHDP aims to provide parents-to-be and parents with anticipatory guidance on childcare, child development and parenting issues through information leaflets, audiovisual resources, workshops and individual counselling. Information related to various aspects of child injury prevention, including home safety, prevention of drug poisoning, risks of leaving child unattended and introduction of childcare facilities, etc. are provided to alert parents to possible injury traps and risks, and educate them on preventive measures specific to children's developmental stage. Besides, the FHS has taken a step further by proactively reaching out to parents/child care workers through other e-channels. Videos on home safety measures are made available in the "Family Health Service YouTube Channel". Through the "Parent-Child e-Link" online membership programmes, e-newsletters on various aspects of parenting and child care, including alerts on home safety measures, are sent to parents according to the age of their growing children. E-newsletters on specific topics are also sent to professional users. An online self-learning parenting programme, "Parenting Made Easy" was launched to facilitate carers / professionals to access evidence-based and practical parenting information of their choice through animations, videos, interactive games and hyperlinks. Important topics on child injury prevention at specific ages are covered in the Parenting Made Easy website. The FHS also delivers talks on injury prevention to child care workers and conducts media interview to raise public awareness on the importance of child injury prevention.
- 2.20 The Student Health Service (SHS) aims to safeguard both the physical and psychological health of school children through comprehensive, promotive and preventive health programmes to enable them to gain the maximum benefit from the education system and develop their full potential. The SHS operates 12 Student Health Service Centres (SHSCs), which provides services such as health assessment, health education and individual health counselling for all primary and secondary school students. The SHS provides regular health talks on injury prevention including sport safety, home accident prevention and outdoor safety to primary and secondary school students attending their annual health check at the SHSCs. Health education materials including pamphlets on sport safety & injury prevention are available and posted on the SHS website.

- 2.21 The Elderly Health Service (EHS) provides primary health care to the elderly so as to improve their self-care ability, encourage healthy living and strengthen family support in order to minimise illness and disability. Visiting Health Teams of EHS conduct integrated assessment for Residential Care Homes for the Elderly (RCHEs) throughout the territory every year. Data on number of falls at each RCHE is collected to help in the planning of fall prevention programmes. Besides, the EHS conducts health talks surrounding the subject of injury prevention at Elderly Health Centres (EHCs), social centres and RCHEs. These topics include “Fall Prevention”, “Home safety”, “Road and Traffic safety”, “Burn & Scald” and “Choking (Swallowing)”. These programmes are developed by a multi-disciplinary healthcare team including doctors, nurses, physiotherapists and occupational therapists, and tailor-made for community dwelling elders and those living in the RCHEs as well as their carers (train-the-trainer). As a model centre of family medicine practice in the primary care setting, EHC performs regular holistic health assessment for enrolled members covering fall risk assessment. Clients identified with the risk of fall are offered multidisciplinary interventions. For instance, these may involve medication modification by doctors, special education and training, prescription of aids (e.g. bedside commode) and home assessment and modification (e.g. recommendation of installing bedside rail) etc. and periodical reviews by allied health professionals such as occupational therapists and physiotherapists. The EHS has collaborated with professional and community organisations such as NGOs, Hong Kong Medical Association (HKMA), and Asian Medical Students’ Association (AMSA) in organising large-scale health seminars, training workshops and exercise classes on fall prevention. In 2013, a total of 40 fall prevention ambassadors were trained in collaboration with a social centre for the elderly who would further disseminate fall prevention messages in the community.
- 2.22 The Primary Care Office (PCO) has published the Reference Frameworks for care of different population groups, namely children and older adults, in primary care settings. These Reference Frameworks provide common reference to healthcare professionals for the provision of continuing, comprehensive and evidence-based care in the community, empower patients and their carers, and raise public awareness of the importance of the proper prevention and management of chronic diseases, as well as health promotion and disease prevention for different population groups. Adoption of safe and healthy behaviours, including injury and fall prevention, are among the health issues being promoted through these reference frameworks.
- 2.23 Selected health educational materials on sports injury prevention are available from the website and pre-recorded telephone information system of the Central Health Education Unit (CHEU).

Interventions to promote injury prevention by other government departments and local organisations

- 2.24 For actions to be effective, there is a need for concerted efforts across a broad public health front, requiring intra-sectoral and inter-sectoral collaborations. Many NGOs and community groups have been implementing health promotion programmes targeting at risk population subgroups and individuals to promote safety awareness and injury prevention.
- 2.25 To foster the development of a safe community, resources can be mobilised across sectors to implement effective injury prevention programmes at local community levels. The Alliance for Healthy and Safe Cities plays an active role in this area. Districts in this Alliance organised a variety of large scale activities, including roving exhibitions, publicity programmes and Home Safety Angel training, etc., to promote safety within the community.

Capacity building for injury prevention

- 2.26 Capacity building strengthens the community's ability to prevent and tackle health problems by increasing people's knowledge and skills. Increased safety literacy can help extend and sustain the effect of injury prevention.
- 2.27 Some organisations have provided training on specific knowledge and skills in rescue and injury prevention. For example, the Hong Kong Life Saving Society organises different types and levels of training courses including pool rescue, open water rescue, as well as aquatic first aids, etc. Courses for emergency medical training such as Advanced Cardiac Life Support (ACLS) Provider Course and Basic Life Support (BLS) Provider Course are organised regularly in Hong Kong to provide training for medical professionals, paramedics and any interested citizens. Some organisations have adopted the train-the-trainer approach to sustain the effect of the promotion programmes. For example, the OSHC, the Centre for Health Education and Health Promotion of the Chinese University of Hong Kong (CHEP) and the Hong Kong Childhood Injury Prevention and Research Association (CIPRA) form an alliance to promote safe and healthy schools. Guidance is provided for the schools to develop safety and healthy policy and management systems to build a safe environment for all students and staff.

Four priority areas identified

- 2.28 The scope of injuries is very broad. It is not possible to cover all types of injuries, settings and population groups. Hence priority areas and a generic framework on injury prevention should be considered to guide actions. According to WHO, in setting priorities for injury prevention, we have to consider available resources, attitude of the public, whether the injury problem has been adequately defined and measured (i.e., who is injured, how, why, and at what rate) and whether an effective measure is available.¹⁴ After deliberation, WGI members reached a consensus that the action plan should focus on injuries with greatest public health impact, pay particular attention to large-scaled settings and approaches such as sports and household; as well as direct efforts to co-operate with relevant stakeholders in respective fields, in order not to duplicate the work already carried out by other government departments or parties.
- 2.29 Based on these principles and following several rounds of discussion, consensus was reached in WGI to focus on four priority areas (sports injuries, falls, domestic injuries other than falls and drowning). These four areas of unintentional injury types will be elaborated further in the next section.
- 2.30 WGI members also deliberated on topics that might not be suitable to be covered as priority areas. Currently, mortality data on traffic incidents were already kept by DH and data on traffic incidents were kept by the Hong Kong Police Force (HKPF). Road Safety was an area well addressed in the Commissioner's Operational Priorities of HKPF in recent years. HKPF would continue to allocate manpower and resource to promote road safety. Moreover, the number of violent crime reported was noted to be decreasing in recent years. As for the number of occupational injury cases, it has been declining over the past ten years through promotion of occupational safety by the OSHC and law enforcement actions by the Labour Department (LD). Since HKPF and LD have long been tackling these injury matters systematically, WGI members considered apt to set the focus on other priority areas.

¹⁴ World Health Organization (2010). *TEACH-VIP E-Learning – Foundations and methods*. Available at: <http://teach-vip.edc.org/documents/lpGp/InjuryPreventionGeneralPrinciples.pdf>, accessed 23 April 2014

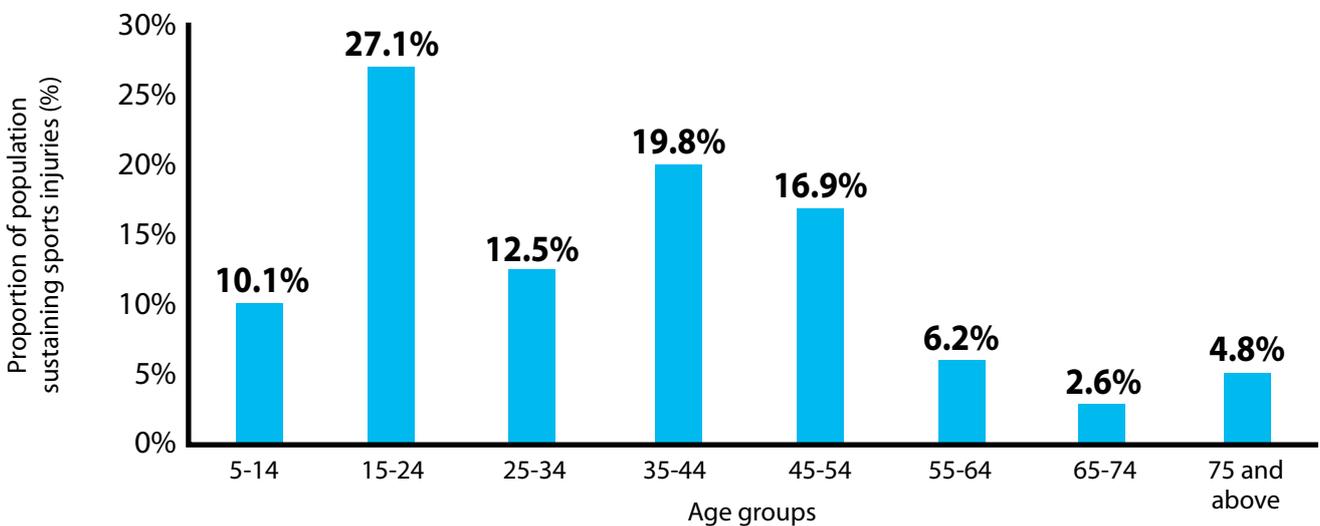
Elaboration of priority areas

Sports injuries

2.31 According to the International Classification of External Causes of Injury (ICECI) of WHO, sports injury is an injury episode in which the person is injured when he/she is engaged in sports-related activity (e.g. competition, recreational participation and warm-up).

2.32 As shown in the *Injury Survey 2008*, among the 460 000 injury episodes sustained in the 12 months before enumeration, 20.8% (or 95 500) took place when the injured persons were engaged in sports-related activities. Strong gender difference was demonstrated in sports injuries, in which male comprised 69.4% of all episodes of sports injuries. A higher proportion of sports injuries occurred among individuals aged 15 to 24 (accounted for 27.1%) and 35 to 44 (accounted for 19.8%), indicative of higher participation in sports activity by these age groups (Figure 8).

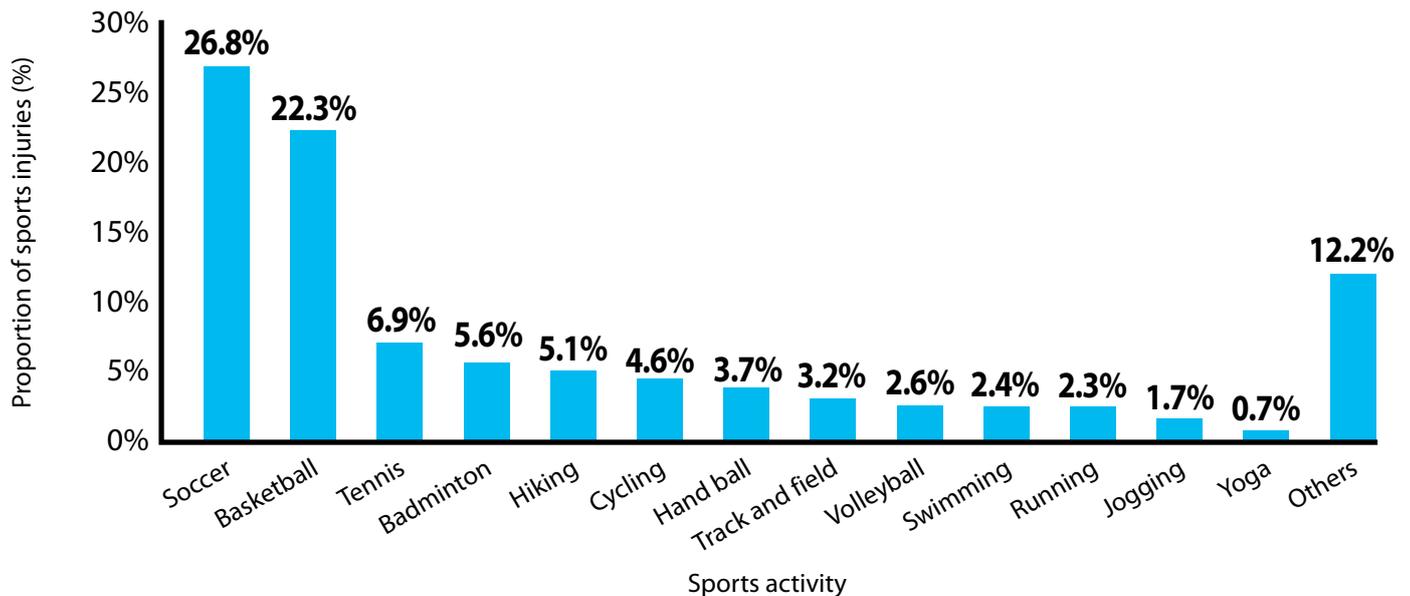
Figure 8: Sports injuries in Hong Kong by age group, 2008



Source: Department of Health (2010). *Injury Survey 2008*

2.33 Analysed by the type of sports activity these injuries involved (Figure 9), soccer and basketball topped the list. Nearly half (49.1%) of the 95 500 episodes of sports injuries were related to soccer (26.8%) and basketball (22.3%).

Figure 9: Sports injuries in Hong Kong by sports activity, 2008



Source: Department of Health (2010). *Injury Survey 2008*

2.34 In Hong Kong, sports participation is actively promoted for its health benefit. Morbidity could have been under-estimated as most people suffering from sports injuries would not require hospitalisation or medical attention. Moreover, statistics on workload of allied health professionals related to sports injuries were not routinely captured and hence not readily available. WGI considered it appropriate to focus on sports injuries since sports is a popular undertaking for many people.

2.35 Measures proven to be effective to prevent sports injuries vary in nature, and may include protective equipment, environmental modification and safety training. The use of protective sports equipment can protect against injuries for certain sports (e.g. helmets for cycling and cricket). The use of helmets when cycling can reduce the risk of head and brain injuries by between 63% and 88%.¹⁵

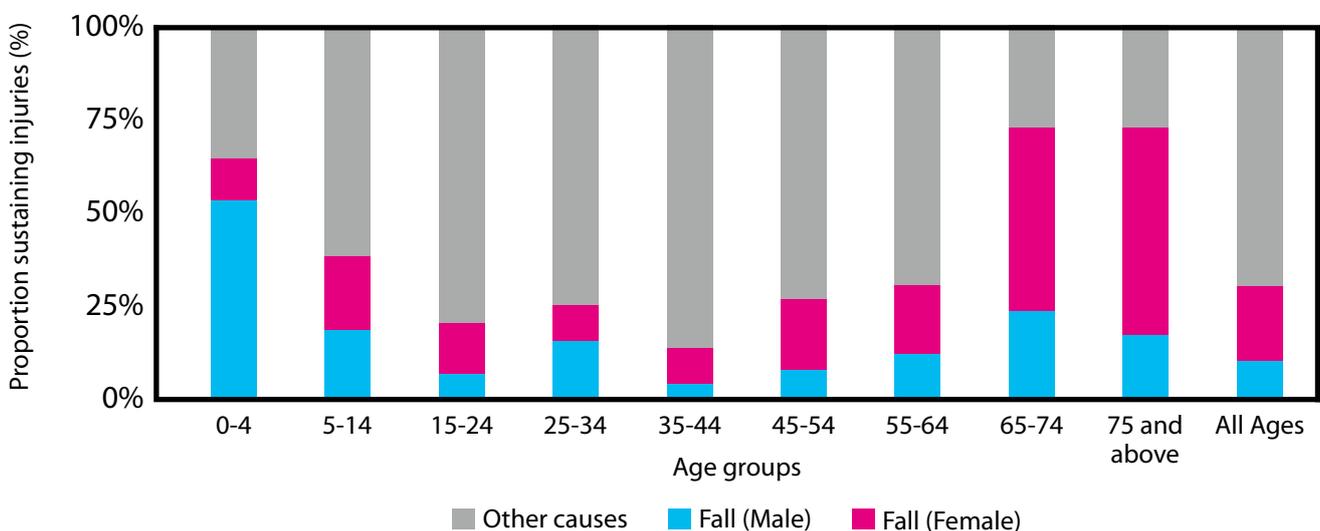
¹⁵ Towner E, Dowswell T, Mackereth C, Jarvis S (2001). *What works in preventing unintentional injuries in children and young adolescents? An updated systematic review*. Prepared for the Health Development Agency (HAD), London. Department of Child Health, University of Newcastle upon Tyne.

- 2.36 Capacity building and skills development are important parts of safe sports promotion. For instance, among people participating in sports, training programmes have been used to improve co-ordination, strength and technique, as well as increase awareness of injury risks and prevention strategies.
- 2.37 Environmental modification also plays an important role in reducing sports injuries. Lowering the height of playground equipment, increasing the depth of impact-absorbing surfaces around equipment and modifying playing surfaces in sports such as gymnasium, track and field, were demonstrated to reduce the severity of the impact from sports or leisure injuries.

Falls

- 2.38 Falls top the toll of unintentional injury-related deaths and hospitalisations. A generally increasing trend is observed in recent years. In 2013, falls caused 232 deaths (12.5% of all injury-related deaths), having increased from 118 deaths (5.3% of all injury-related deaths) in 2004. There were 39 450 fall-related hospitalisations (40.3% of all injury-related hospitalisations) in 2013, representing an increase from 30 576 fall-related hospitalisations (41.6% of all injury-related hospitalisations) in 2004.
- 2.39 Falls demonstrate strong age relevance, as they are more prevalent at the extremes of life (Figure 10). Among injuries sustained due to all causes, falls accounted for 73.0% in individuals aged 65 years and above. It accounted for 63.9% of all causes of injuries in individuals aged 0 to 4. Moreover, falls demonstrate an obvious gender difference. In the younger extreme of age, i.e. persons aged 14 and below, 57.4% of falls occurred among male children (versus 42.6% in female children). In persons aged 65 or above, the pattern is reversed - 72.3% occurred in female and 27.7% in male.

Figure 10: Proportion of falls among all causes of injuries by age group and gender, 2008



Source: Department of Health (2010). *Injury Survey 2008*

- 2.40 High prevalence of unintentional residential fall injury was observed among children and elderly. The major disease burden related to falls also occurred among these population subgroups. For example, according to data collected in a collaborative study between Kwai Tsing Safe Community and Healthy City Association and Princess Margaret Hospital (PMH), elderly falls was identified as one of the major injury causes in that district, and falls in elderly care centres were not uncommon.¹⁶ According to another local study¹⁷, high population density is one of the risk factors for this situation. Crowded living environment played an important role by contributing to a high prevalence of falls, especially in the domestic setting.
- 2.41 Many studies showed that home modification intervention alone had no significant effect on elderly falls outcome. Multi-factorial interventions including exercise to build muscle strength, vision correction, home hazard management showed more promising effects.¹⁸

Domestic injuries (other than falls)

- 2.42 Home is the place where people spend most of their time. Domestic injuries recorded the highest injury rate among all environmental settings, according to the Injury Survey 2008. Domestic injuries include a variety of injuries sustained through different mechanisms. Domestic injuries have thus become a focus of attention among public health professionals.
- 2.43 About one-fifth (20.4%) of the injury episodes took place at home, followed by transport area: public highway, street or road (17.8%) and sports or athletics area (13.5%). It was estimated that 94 000 episodes of domestic injuries occurred in 2008. Domestic injuries accounted for the largest share among all types of injuries in elderly and female. In elderly, domestic injuries accounted for 43.1% among all injury types. Among all age groups, persons aged 0-4, 65-74 and 75 and above had higher rate of sustaining domestic injuries compared with other age groups (Figure 11).

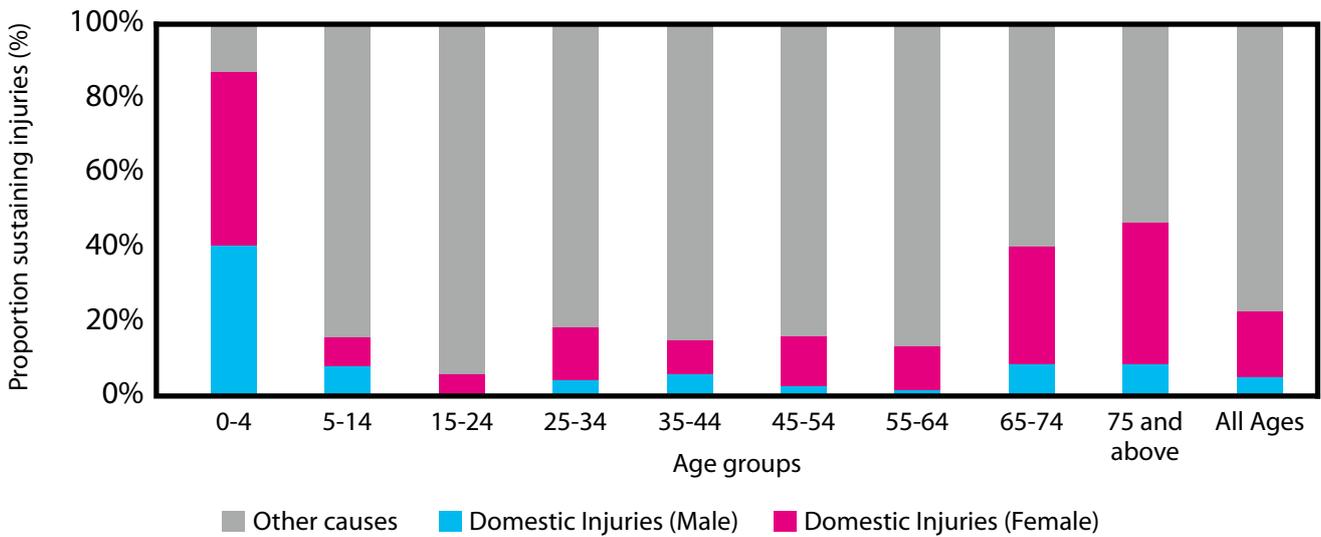
¹⁶ Kwai Tsing Safe Community and Healthy City Association. *Injury Surveillance Report*. 2010.

¹⁷ Chow CB, Luis BP, et al (2003). *Unintentional residential child injury surveillance in Hong Kong*. *J Paediatr Child Health*. 2003 Aug;39(6):420-6.

¹⁸ *Modification of the home environment for the reduction of injuries (Review)* (2009). *Cochrane Collaboration*. 2009, Issue 1.

2.44 Strong gender difference was demonstrated in domestic injuries, in which female comprised 78% of all episodes of domestic injuries. In female, injuries occurring at home accounted for 29.8% which formed the largest share among all settings, followed by those occurring in transport areas including public highways, streets or roads (19.4%); recreational areas, cultural areas, or public buildings (12.1%); and schools and educational areas (10.7%).

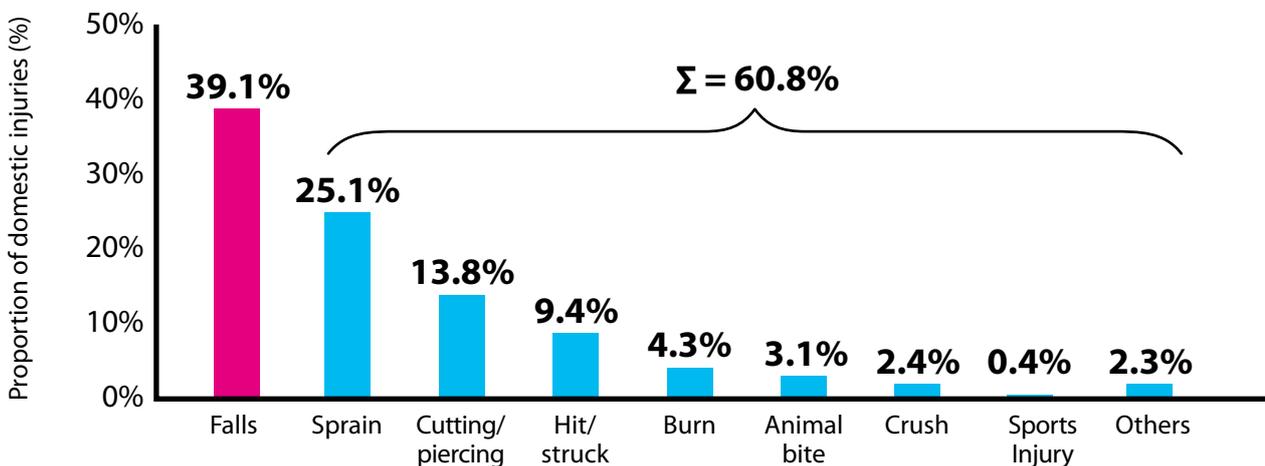
Figure 11: Domestic injuries in Hong Kong by gender and age, 2008



Source: Department of Health (2010). *Injury Survey 2008*

2.45 According to the Injury Survey 2008, domestic injuries were due to several major causes, namely falls, sprain, cutting/piercing, hit/struck, burn, animal bite and crush. Causes other than falls accounted for 60.8% of all domestic injuries (Figure 12).

Figure 12: Domestic injuries by causes, 2008



Source: Department of Health (2010). *Injury Survey 2008*

- 2.46 Measures proven to be effective to improve home safety vary widely in nature. There is good evidence for the effectiveness of safety education programmes in increasing safety behaviours and the use of safety devices.¹⁹ The utilisation of home safety equipment such as cupboard catches, stair gates, window locks, fire guards, electric socket covers, thermometers to test water temperatures, anti-scald devices in hot water taps and smoke alarms can offer protection against injuries occurring in the home. Studies showed that window safety mechanisms to prevent children from opening windows, such as bars and position locking devices, are effective measures to prevent falls. Window bars have been shown to reduce deaths from window falls by 35%.²⁰ Secure storage for poisons removes a larger portion of poisoning risk than parental supervision and may be an effective intervention of preventing poisoning injury.^{21,22}
- 2.47 On the other hand, product safety is important to safeguard consumer health. With advancement in technology and product engineering, safer products are designed to prevent injury occurrence. Comparative tests can alert them to product hazards, help consumers make rational choices, and induce improvements in product quality and safety.
- 2.48 To achieve a high adoption of proven safety interventions, the two basic approaches are to raise awareness and increase accessibility to these measures. For safety interventions involving behavioural change, effort should be made to educate members of the public the existence of hazard and effectiveness of certain measures.
- 2.49 Although many sectors are already working on this area, we still observe a considerable number of domestic injuries every year. There is a possibility that those who need to know may fail to get the message. This rightly illustrates the importance of targeted risk communication.

¹⁹ Harborview Injury Prevention and Research Center (2001). *Best Practices*. Seattle, University of Washington.

²⁰ Spiefel CN, Lindaman FC (1995). *Children can't fly: a programme to prevent childhood mortality from window falls*. *Inj Prev* 1995; 1(3): 194-8.

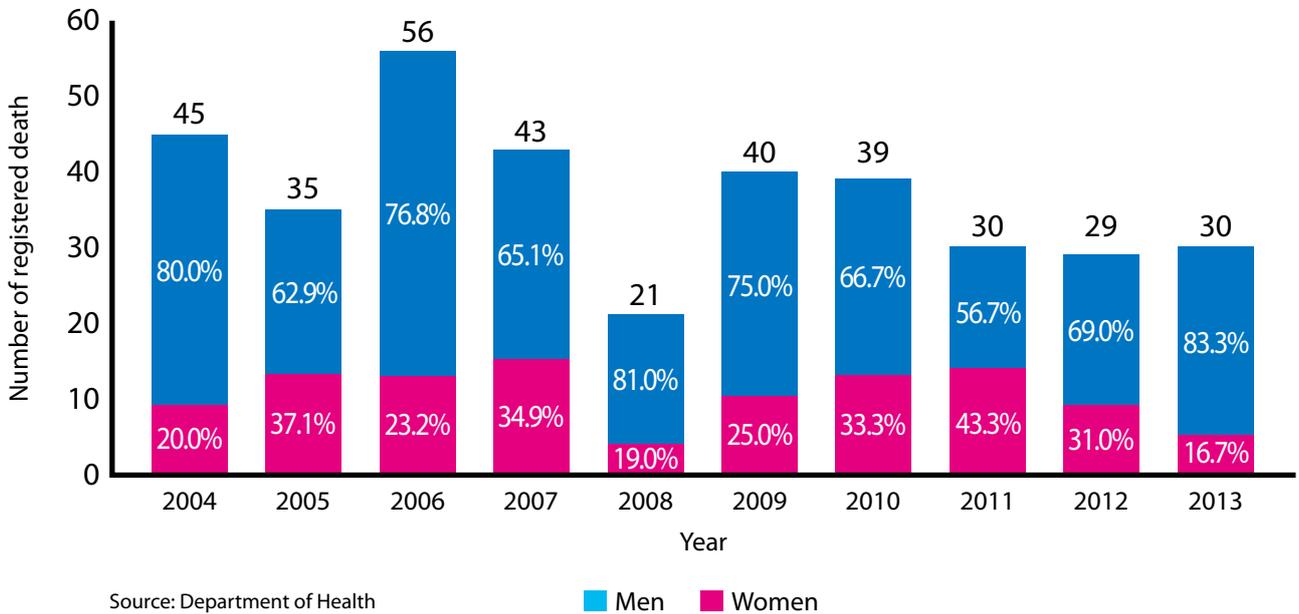
²¹ Krug A, Ellis J, Hay I, Mokgabudi N, Robertson J (1994). *The impact of child-resistant containers on the incidence of paraffin (kerosene) ingestion in children*. *S Afr Med J* 1994; 84(11): 730-734.

²² Woolf AD, Saperstein A, Forjuoh S (1992). *Poisoning prevention knowledge and practices of parents after a childhood poisoning incident*. *Pediatrics* 1992; 90(6): 867-870.

Drowning/near-drowning

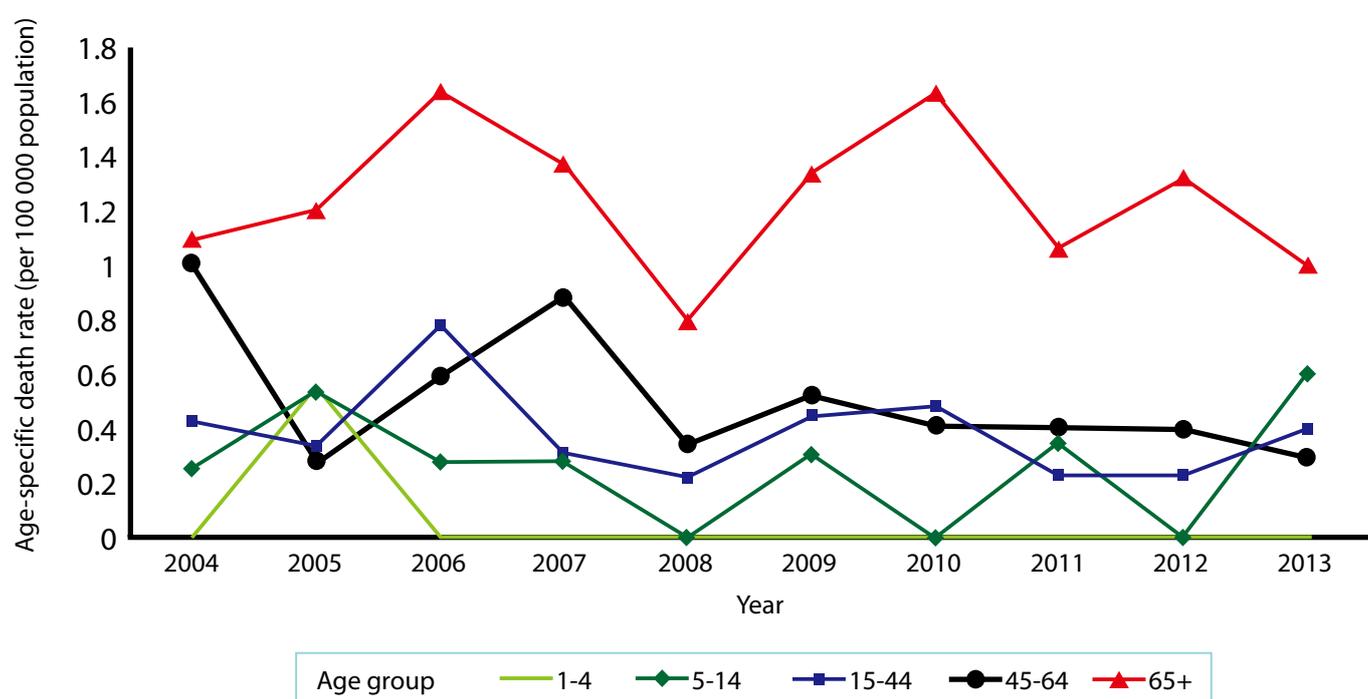
2.50 The number of accidental drowning and submersion deaths fluctuated over the past ten years (Figure 13). There were 21 to 56 deaths annually. There was no clear increasing or decreasing trend. In 2013, there were 30 death cases resulting from accidental drowning and submersion. Drowning, from time to time, caused substantial mortality in Hong Kong.

Figure 13: Number of registered death due to accidental drowning and submersion (W65-W74) by gender in Hong Kong, 2004-2013



2.51 Strong gender difference is demonstrated in drowning-related mortality statistics, in which male comprises around 60% to 80% of death cases annually. Besides, obvious age difference is noted in drowning-related mortality statistics. Age-specific death rate due to accidental drowning and submersion increases with age. Age-specific death rate was the highest for the age group 65 and above in the past decade (Figure 14).

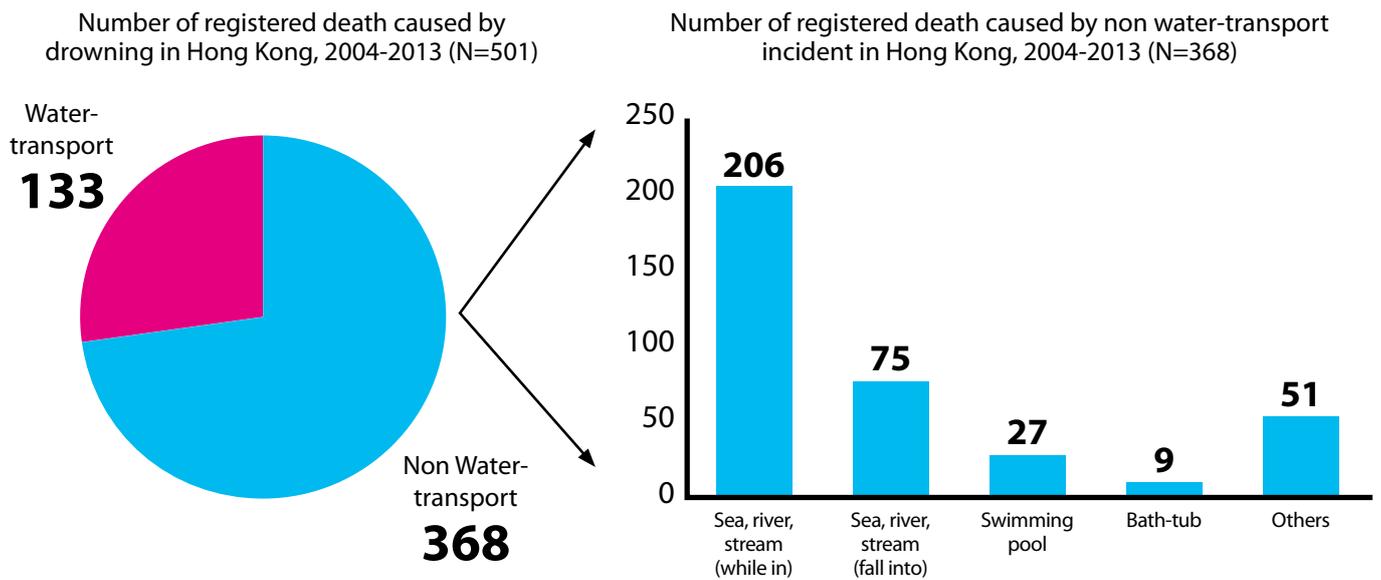
Figure 14: Age-specific death rate due to accidental drowning and submersion (W65 - W74) in Hong Kong, 2004-2013



Source: Census and Statistics Department, Department of Health

2.52 Among all 501 registered deaths due to drowning in the past decade, 133 (26.5%) were water-transport related and 368 (73.5%) were not (Figure 15). Among these 368 non water-transport related drowning cases, most happened in natural water (e.g. sea, river and stream) followed by swimming pool and bath-tub.

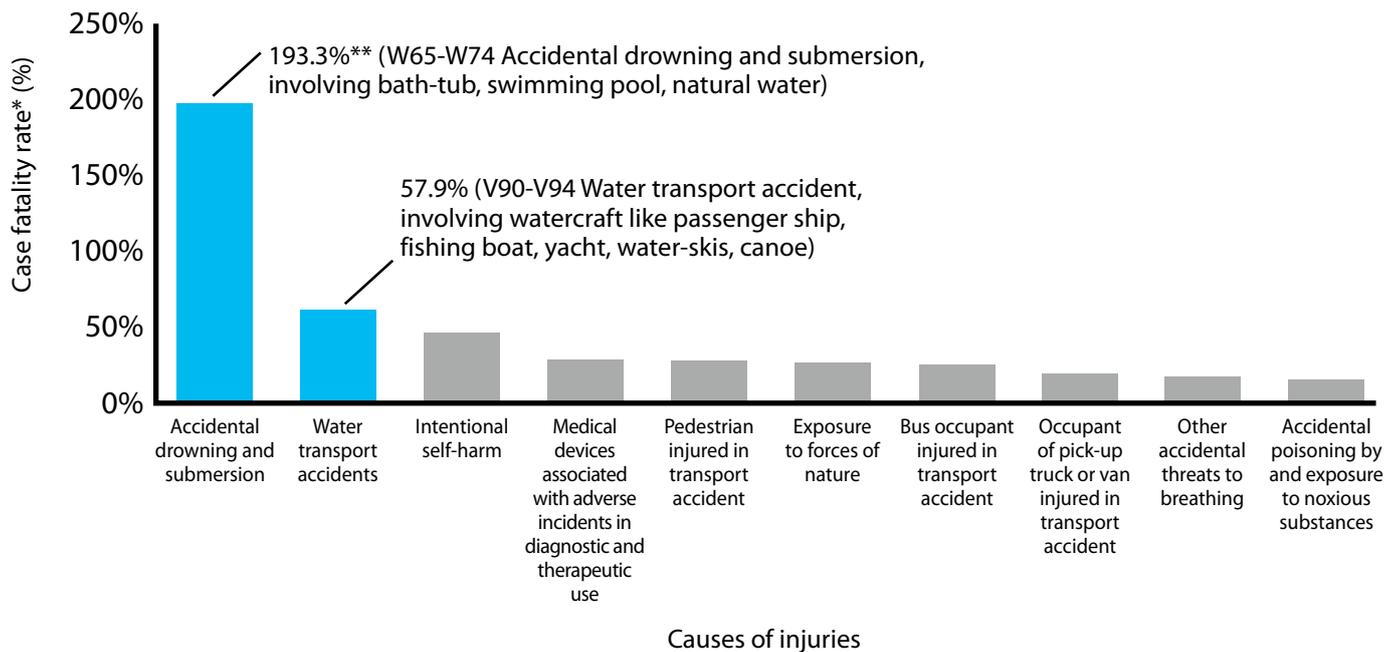
Figure 15: Number of registered death caused by drowning in Hong Kong, 2004-2013



Source: Department of Health

2.53 Although the number of deaths due to drowning is small compared with other major types of injuries, fatality rate is exceptionally high among drowning cases (Figure 16). In the past decade, for every ten persons admitted to the hospital due to water-transport accident (V90-V94), nine ended up in death. Figures were even more alarming for accidental drowning and submersion (W65-W74). For every ten persons admitted to the hospital, seventeen ended up dying. This was because casualties were usually sent directly to the public mortuary without the need for hospital admission. This phenomenon is unique for drowning, among all types of injuries (V01-Y98) observed in Hong Kong. In other words, drowning/near-drowning is more lethal compared with other causes of injuries. As shown in corresponding figures from the past decade, drowning has one of the highest fatality rate among all injuries. The significant public health impact should not be underestimated.

Figure 16: Causes of injuries by ten leading case fatality rate in Hong Kong, 2012



Source: Department of Health

* Case fatality rate referred to the proportion of registered deaths in the number of in-patient discharges and deaths.

** Case fatality rate exceeded 100% because some casualties were sent directly to mortuary without admitting to hospital. These cases thus did not appear in hospital record, i.e. in-patient discharges and deaths.

2.54 Utilisation of lifeguard service and swimming only in guarded beaches or pools prevent drowning, with strong evidence. These are areas where effort has been made to contain the risk of drowning. There are other areas where actions can be introduced. Examples of neglected or hidden hazards include outdoor water bodies (e.g. streams and rivers) and indoor water bodies (e.g. washing machines filled with water and not in operation).



3

Actions to strengthen prevention of unintentional injuries



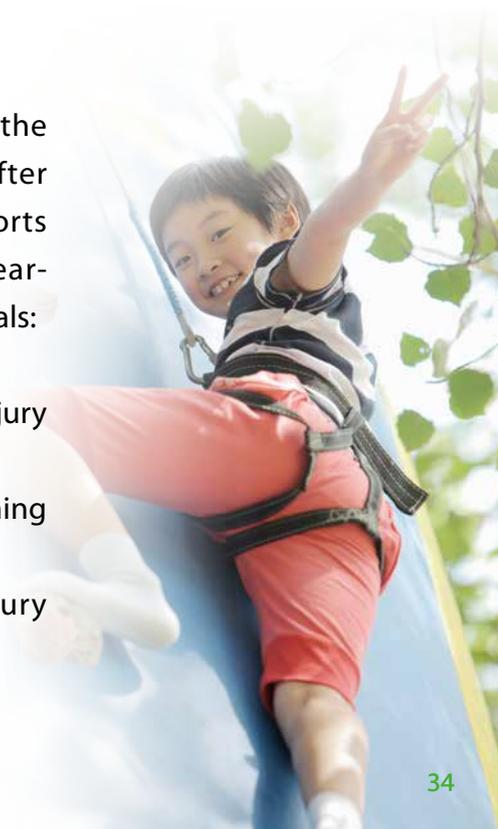


3. Actions to strengthen prevention of unintentional injuries

- 3.1 In 2008, DH published a strategic framework document titled *“Promoting Health in Hong Kong: A Strategic Framework for Prevention and Control of Non-communicable Diseases”* with the overall goal to increase positive health and quality of life of the people of Hong Kong.
- 3.2 To achieve the above goal, different priority areas were identified and three working groups including the current WGI were established. The WGI recognises the importance of concerted efforts of the Government and different sectors in the community to create a sustainable environment to strengthen injury prevention. It is of equal importance that individuals take responsibility for his or her own health, as well as the health of their families and communities, by making informed and healthier choices with regard to injury prevention.

Goals

- 3.3 Following careful review of overseas evidence, examination of the local situation and consultation with stakeholders, the WGI, after deliberations, identified four areas of concern, namely falls, sports injuries, domestic injuries (other than falls), and drowning/near-drowning. Recommendations are formulated with the following goals:
- 1 To strengthen injury surveillance by building a sustainable injury surveillance system;
 - 2 To raise public awareness of injury prevention by strengthening risk communication;
 - 3 To empower the public to make informed choices on injury prevention; and
 - 4 To reduce the burden of injuries in Hong Kong.



Specific actions

3.4 To achieve the stated goals, a total of 16 specific actions are proposed in support of the 9 recommendations underpinning 5 strategic directions. Table 2 provides a summary of these actions.

Strategic direction 1: Support new and strengthen existing health promotion activities on injury prevention

(Recommendation 1A) Develop and implement a health communication strategy and advocacy in support of injury prevention

3.5 Many injuries and suffering can be avoided if preventive measures are properly taken. Hence, it is of utmost importance that the public is informed and empowered with respect to preventive measures. Effective risk communication is a fundamental tool to assist the public to recognise risks and make informed choices about their health and lives. Different organisations are currently promoting injury prevention but their efforts are scattered and not systematic. If there is better collaboration and cooperation between different parties, synergistic effects can be generated, thus propagating health messages to the public more effectively.

Action 1: Devise a health communication strategy to articulate messages positively as safety promotion and performance enhancement in addition to the traditional ways as injury prevention and damage minimisation

3.6 One important aspect of injury prevention is to disseminate key messages to the public to raise their awareness on injury prevention. However, the public is not a homogenous group and therefore the messages must be tailor-made to different audiences. To achieve this, the DH should take the lead to devise a health communication strategy customised to various audiences on relevant injury prevention subjects using appropriate means. Through organised and systematic efforts, injury prevention messages can be effectively communicated with specific target groups. Key themes and ideas can be systematically structured within the communication strategy.

(Recommendation 1B) Strengthen existing health promotion activities on injury prevention and maximise the utilisation of readily available resources for injury prevention

- 3.7 Small-scale and short-term health promotion activities may generate population health impacts which are brief and limited in scale. By pooling resources, there is a higher chance to maximise health improvement effects. With closer collaboration and organised efforts among stakeholders, existing health promotion activities on injury prevention can be strengthened and resources better deployed for the good of society as a whole.

Action 2: *Make use of existing and newly obtained mortality and/or morbidity data, credible sources of information and evidence-based practices to develop injury prevention messages in such forms that appeal to varying audiences and to support health promotion activities*

- 3.8 Currently, there are stakeholders promoting injury prevention such as the Hong Kong Jockey Club Sports Medicine and Health Sciences Centre which focuses on sports injury prevention. It is also noted that recommendations on injury prevention were made in the *Coroners' Report* (published annually by the Coroner's Court) and the *Reports of the Child Fatality Review Panel* (published by the Child Fatality Review Panel which is an independent multi-disciplinary non-statutory body with members appointed by the Director of Social Welfare). These recommendations offered insight into population groups at risk of sustaining fatal injuries. These reports provide insights into promotional gaps to be addressed at public education level. The DH will conduct regular reviews, for instance, on an annual basis, into these reports to extract useful messages to communicate with the wider public.

Strategic direction 2: *Generate a comprehensive and effective information system to understand the epidemiology of injuries and to provide advice and support on prevention of injuries*

(Recommendation 2A) Widen the scope of injury surveillance

- 3.9 The WHO defined surveillance as "systematic ongoing collection, collation and analysis of data and the timely dissemination of information to those who need to know so that action can be taken".²³ Injury surveillance is essential. Without effective surveillance, it would be hard to identify the trends and at-risk groups, let alone formulating specific preventive measures. The sustainability of an injury surveillance system is also crucial as surveillance needs to be ongoing to reflect time trends. Moreover, an injury surveillance system will need to record the injury type as well as the details of each incident. As a start, the existing administrative statistics of relevant stakeholders is a good source of data to be used for surveillance purpose.

²³ World Health Organization (2013) Surveillance. Available at: http://www.who.int/tobacco/surveillance/about_surveillance/en/, accessed 11 October 2013

Action 3: *Explore the use and systematic analysis of selected data collected in Hospital Authority (HA) hospitals to strengthen knowledge on epidemiology of injury cases requiring Accident and Emergency (A&E) attendance and hospitalisation*

3.10 This proposed action focuses on analysing the types of injuries that require A&E attendance or hospitalisation. A review of existing sources of local surveillance data on injuries showed that monitoring of most parts of the injury pyramid is already in place. Injuries ranging from fatal to untreated ones are captured by the Death Registry, coroner records, in-patient discharge records of HA hospitals and the various surveys. Injuries resulting in admissions to A&E are captured by the domestic injury information systems in several HA hospitals, as a proxy of this type of injuries. However, analysis on injury-related data captured in A&E is minimal and there is no systematic dissemination of such information to those who need to know. With surveillance of A&E data, a more complete picture of the burden caused by injuries can be obtained and indicators for assessing the burden of injuries can be calculated.

Action 4: *Carry out a review of drowning cases kept by the Coroner's Court, with a view to understanding the demographic details, contributory factors of fatal incidents for the development of injury prevention messages*

3.11 The mortality statistics currently maintained by DH is a good source of information for studying the overall pattern of fatal drowning cases. However, it offers minimal information on the demographic characteristics and mechanisms of the fatalities. With more thorough understanding of these factors, appropriate measures to prevent fatal drowning can be possible.

3.12 This proposed action suggests that a review should be conducted on drowning cases kept by the Coroner's Court. As there were around 30 - 60 cases of drowning each year in the past decade, reviewing fatal drowning accidents in the past 5 - 10 years would be a feasible and manageable exercise. If the momentum of this exercise is maintained, the content of the review will form a good basis for routine drowning surveillance.

Action 5: *Explore a pilot programme to assist schools to implement an injury surveillance system to identify contributing and precipitating factors for injuries within the school and pinpoint areas for improvement actions*

3.13 This proposed action focuses on falls, sports and other injuries occurring at school. According to the *Injury Survey 2008*, 35.6% of injuries sustained by children aged 14 and below occurred in schools or educational areas.¹¹ Thorough understanding of the epidemiology of injuries is a prerequisite for effective injury prevention; hence surveillance of injuries occurring in schools is essential. Currently there is no standardised and universally adopted injury reporting system concerning falls, sports injuries and other injuries occurring at schools and each school has its own internal procedures in handling such incidents. Moreover, it is noted that even if the practice of recording injuries is in place, the purpose is more on recording administrative management of incidents rather than identification of causation and prevention of injury recurrence. The lack of good documentation of injuries and preventive actions also puts schools in a less advantageous position when faced with complaints and possible litigation. With collaboration between stakeholders including the DH, the OSHC, the Education Bureau (EDB), School Councils and some pilot schools, it is hoped that existing good practices can be harnessed to form a practical system to record and better understand the nature of injuries occurring in schools.

Action 6: *Explore the possibility of accessing new sources of injury data to enrich the existing injury surveillance system to alert the public where injuries are more to occur*

3.14 The DH currently maintains mortality data, whereas morbidity data can be accessed from HA. Other forms of morbidity data can be obtained from sources such as the administrative statistics of the Auxiliary Medical Service (AMS) regarding injuries that occur on cycling tracks etc. This information would be useful for studying the characteristics of injuries relating to cycling, which is becoming increasingly popular. With routine collection, collation and analysis of these data, the public can be alerted to the “black spots” and “risk behaviours” which commonly result in injuries. In respect of the means of information dissemination, both traditional means e.g. setting up warning signs at black spots and electronic means e.g. websites or mobile applications can be considered.

(Recommendation 2B) Strengthen the existing injury surveillance system to make it useful and sustainable

3.15 The DH has conducted a number of surveys with the component of injuries in the past. In 2003-2004, the DH conducted the first PHS to study the patterns of health status and health-related issues of the general population in Hong Kong for persons aged 15 years and above. The second round of PHS is now under commissioning. In 2005-2006, the CHS was conducted among children aged 14 and below in Hong Kong to provide supplementary information to the PHS by including baseline data on the health and well-being of children in Hong Kong. Since October 2004, the BRFSS of the DH has continuously monitored the trend of health-related behaviours for adults aged 18-64 through a series of telephone surveys conducted systematically and periodically. In 2008, the DH conducted the Injury Survey to collect pertinent information on the characteristics and the burden of unintentional injuries in Hong Kong population.

Action 7: *By conducting in-depth analysis on existing and updated data collected from surveys, strengthen understanding of the pattern and trend of injuries*

3.16 Data from surveys conducted by the Non-Communicable Disease Division of the Surveillance and Epidemiology Branch of Centre for Health Protection have been used to publish articles written by the DH, other organisations and researchers. To better utilise these survey data, more in-depth analysis may be conducted and articles published and widely disseminated in various media to reach different audiences.

(Recommendation 2C) Promote research of feasibility, efficiency and cost-effectiveness of interventions to prevent injuries

3.17 A substantial amount of studies on the effectiveness and cost-effectiveness of interventions to prevent injuries have been conducted overseas. On the other hand, local studies are limited and it is important to investigate the possible effect and feasibility of new and existing measures to prevent injuries. In this regard, academic institutions and other NGOs should be encouraged to submit applications for funds to conduct research studies relating to injury prevention.

Action 8: *Encourage more research on the four major types of injuries identified (i.e. sports injuries, falls, domestic injuries other than falls and drowning)*

3.18 The Research Office of the Food and Health Bureau (FHB) organises a forum every year to encourage relevant parties, including academia and NGOs, to apply for the HCPF and HMRF. In order to encourage potential applicants to conduct research on injury prevention, the DH could highlight the thematic priorities on injury prevention during the forums organised by FHB.

Strategic direction 3: Strengthen partnership and foster engagement of all relevant stakeholders

(Recommendation 3A) To work with government bureaux/departments, other health promotion partners, NGOs, schools, employees and employers of different industries to develop and implement measures that are sensitive to the needs of the public in achieving prevention of injuries

3.19 Health promotion and disease prevention require the involvement of not only the health sector but the whole community. Working in partnership with all relevant stakeholders at community level is crucial for the success of injury prevention. Given the complexity and challenges in relation to injury prevention, health authorities, healthcare professionals, government departments, the education sector, the housing sector, the sports sector and other NGOs have to work together to develop and implement measures that are sensitive to the needs of the public in achieving injury prevention. The DH will play a bridging role in these processes, bringing together stakeholders and promoting the sharing of experience and good practices, to enable a larger part of the population to benefit.

Action 9: Support schools to strengthen injury prevention through voluntary participation in health and safety programmes covering school policy, injury surveillance, first aid training, staff development, student education, warm-up exercise before sports and parental engagement, with a long term goal to facilitate the implementation of EDB's Healthy School Policy.

3.20 The component of injury surveillance will be implemented as a first step. Other components will be implemented consequentially. Guidelines for schools on setting up a system to record injuries are useful for protecting the schools themselves and developing strategies to prevent further injuries among staff and the student population. Schools will be supported by EDB and DH in strengthening injury prevention strategies and measures in schools, including record keeping on cases of injuries. It must be emphasised that the aim of keeping an injury record is to help the school design and implement preventive measures rather than finding fault.

3.21 With surveillance systems in place, patterns of injuries with respect to time, place and person could be readily identified, studied and compared before and after interventions. Interventions such as a comprehensive school policy, first aid training, staff development, student education, warm-up exercise before sports and parental engagement could be customised and promoted to meet the needs of school population. Existing safe school programmes and initiatives could also be promoted for adoption by a greater number of schools.

Action 10: Collaborate with the Leisure and Cultural Services Department (LCSD) to strengthen sports injury awareness, surveillance and prevention

3.22 It is noted that a large number of people use the facilities of or participate in sports activities organised by the LCSD. In 2012-13, the LCSD organised about 37 800 recreational and sports activities for more than 2 136 600 participants of all ages and abilities.²⁴ The LCSD plays a significant role in preventing sports injuries. The DH will collaborate with the LCSD to enhance efforts on sports injury awareness, surveillance and prevention.

3.23 Injury-related administrative statistics of LCSD's sports amenities (e.g. sports centre, beach and swimming pool) might be acquired as a proxy of conducting surveillance on sports injuries. This injury surveillance initiative will be a continuous one, and the frequency of obtaining data from LCSD is targeted to be once a year. Aggregated statistical tabulation and description of these tables will be published in a report/article in printed or electronic form for wider dissemination.

Action 11: Engage stakeholder groups (ranging from service providers to users) and raise their awareness on injury prevention and safety promotion through briefing(s), sharing session(s) or seminar(s)

3.24 Seminars would be held when the action plan on injury prevention is launched, so that messages on injury prevention could be disseminated to relevant stakeholders. Depending on the audience targeted, the content of these gatherings should be customised to achieve the greatest buy-in and impact.

Strategic direction 4: Build capacity and capability to prevent injuries

(Recommendation 4A) Develop personal skills to adopt injury preventive measures through communication of evidence-based advice

3.25 Effective risk communication is a fundamental tool to assist the public to make informed choices about health and living. Many injuries happen because the public lack the knowledge or understanding of the risk of injuries and injury prevention skills. With knowledge and awareness, safety literacy is increased and the public are more likely to take actions to prevent injuries. Thus, the WGI recommends developing evidence-based advice to empower and enable the general public to make informed choices about injury prevention.

²⁴ Leisure and Cultural Services Department (2013) *Annual Report 2012-2013*. Available at: <http://www.lcsd.gov.hk/dept/annualrpt/2012-13/en/leisure/leisure03.html>, accessed 25 October 2014

Action 12: *Raise awareness and safety literacy of cyclists for them to adopt safe practices and protective gear while cycling*

3.26 Cycling is a type of physical activities that has gained popularity in recent years in Hong Kong. However, a large number of fatal and severely injured cases of cycling-related injuries have also been recorded.

3.27 In the routine cycling safety workshops organised by Road Safety Council for primary and secondary school students, elements of injury prevention and performance enhancement will be recommended to the coach of these workshops. These elements include (1) warm-up and cool-down exercises; (2) updated local situation of cycling injury (e.g. surveillance results from AMS data); (3) proper cycling gear; and (4) safe cycling skills and road manner. Evaluation of such educational activities is also recommended.

Action 13: *Institute community-wide education on interventions proven to be effective in injury prevention in high risk situations.*

3.28 This proposed action focuses on domestic injuries and falls. The Consumer Council and the Hong Kong Customs and Excise Department (C&ED) have publications on product safety, especially on installations and products that are used in the domestic setting. Such information will be reviewed and leveraged on in relevant risk communication activities.

Action 14: *Promote knowledge-based interventions to PE teachers and coaches as a means to raise sports performance and prevent sports injuries using a train-the-trainer approach*

3.29 Developing skills for sports coaches on sports injury prevention could be more efficient than teaching individual players as the trainers, after being equipped with the knowledge and skills on sports injury prevention, can in turn teach individual sports players on knowledge and skills while serving as role models themselves. Training sessions to PE teachers and coaches may be organised with the help of the EDB and LCSD to cover concepts, principles and practices of injury prevention in specific settings as well as exercises designed and tested to prevent sports injuries and enhance sports performance. Expertise on sports injury prevention may be sought from relevant sports experts.

(Recommendation 4B) Strengthen community awareness and actions to prevent injuries

3.30 The WGI considers it important to empower the general public with skills and knowledge of injury prevention. By using the train-the-trainer approach, messages of injury prevention can be more quickly and effectively disseminated to individuals. Hence, capacity building programmes targeting teachers, sports coaches and peer leaders should be organised to generate a cascading effect within the community.

Action 15: *Produce teaching aids to strengthen safety awareness and promote injury prevention actions by staff and students. Content to be introduced should be tailored to students' academic needs*

3.31 Schools are a good starting point for the education of injury prevention as children can benefit directly and also propagate the messages to their families. The DH will study the current curriculum and teaching resources, and where appropriate, make recommendations of age-appropriate information and materials on injury prevention to be introduced. Teaching aids for primary school students on injury prevention, called the "Injury Prevention Programme in Primary Schools", were prepared by the CIPRA. In order not to reinvent the wheel, these teaching aids will be reviewed by teachers before considering revision and promotion of use. After collection of their comments, changes could be made to the teaching aids as appropriate before promotion for use by teachers as teaching aids.

Strategic direction 5: Ensure a health sector that is responsive to the NCD challenges and to improve the healthcare system

(Recommendation 5A) Engage healthcare professionals in promoting messages and practices that prevent injuries and identifying and managing at-risk groups

3.32 Primary care setting is an important place to promote health to the public including those at-risk of injuries, as family doctors and other primary care providers are often the first contact point for members of the community. Contact during consultation allows primary care providers to offer advice on injury prevention such as providing safety tips/self-help materials, brief intervention/counselling and referral to specific services as appropriate. The WGI recommends engaging health professionals in reducing injuries.

Action 16: Engage primary care providers in dissemination of injury prevention information to increase the accessibility of at-risk groups to community support

- 3.33 People with functional disabilities, degenerative conditions, problem of poly-pharmacy or childcare problems are at higher risk of falls and other types of domestic injuries. As primary care practitioners are often the first point of contact for these client groups, by raising injury awareness, they stand a better chance of identifying and managing at-risk groups. The *Hong Kong Reference Framework for Preventive Care for Children in Primary Care Settings* and *Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings* provide appropriate guidance and reminders for doctors to instill concepts and skills in at-risk populations and their carers for promoting home safety and injury prevention.
- 3.34 Some NGOs are providing community support to elderly at risk of falls. These consist of home assessment and modification, advice on use of walking frames and assistive devices, training of carers, etc. Such service networks should be promoted and extended to cover primary care providers so that persons at risk of fall may be referred to access already existing community support services.

Table 2: Lead action parties, targets and timeframe

| Strategic directions | Recommendations | Actions | Lead action parties | Targets and timeframe |
|--|--|--|---|--|
| (1) Support new and strengthen existing health promotion activities on injury prevention | <ul style="list-style-type: none"> • (1A) Develop and implement a health communication strategy and advocacy in support of injury prevention | <p>[Action 1] Devise a health communication strategy to articulate messages positively as safety promotion and performance enhancement in addition to the traditional ways as injury prevention and damage minimisation</p> | <ul style="list-style-type: none"> • DH | Starting from 2015, a health communication strategy for different target groups will be developed and implemented. |
| | <ul style="list-style-type: none"> • (1B) Strengthen existing health promotion activities on injury prevention and maximise the utilisation of readily available resources for injury prevention | <p>[Action 2] Make use of existing and newly obtained mortality and/or morbidity data, credible sources of information and evidence-based practices to develop injury prevention messages in such forms that appeal to varying audiences and to support health promotion activities</p> | <ul style="list-style-type: none"> • DH • Other relevant Government departments | From 2015, evidence, facts, statistics and relevant information will be collated and updated regularly to support health promotion activities. |
| (2) Generate a comprehensive and effective information system to understand the epidemiology of injuries and to provide advice and support on prevention of injuries | <ul style="list-style-type: none"> • (2A) Widen the scope of injury surveillance | <p>[Action 3] Explore the use and systematic analysis of selected data collected in Hospital Authority (HA) hospitals to strengthen knowledge on epidemiology of injury cases requiring Accident and Emergency (A&E) attendance and hospitalisation</p> | <ul style="list-style-type: none"> • DH • HA | By 2015-16, a mechanism will be devised to obtain injury-related data from HA for analysis. |
| | | <p>[Action 4] Carry out a review of drowning cases kept by the Coroner’s Court, with a view to understanding the demographic details, contributory factors of fatal incidents for the development of injury prevention messages</p> | <ul style="list-style-type: none"> • DH • Other relevant Government departments | In 2016, the review on drowning cases kept by Coroner’s Court will be completed. |
| | | <p>[Action 5] Explore a pilot programme to assist schools to implement an injury surveillance system to identify contributing and precipitating factors for injuries within the school and pinpoint areas for improvement actions</p> | <ul style="list-style-type: none"> • DH • EDB • Academia • OSHC | Starting from 2015, DH will engage a number of primary and secondary schools in a pilot project to learn about the injury report software Community Injury Surveillance System (CISS) developed by OSHC and explore possibility of adoption to enhance injury surveillance in schools. |

| Strategic directions | Recommendations | Actions | Lead action parties | Targets and timeframe |
|---|---|--|---|---|
| | | [Action 6] Explore the possibility of accessing new sources of injury data to enrich the existing injury surveillance system to alert the public where injuries are more to occur | <ul style="list-style-type: none"> • DH • Other relevant Government departments | With effect from 2015, DH will enhance the injury surveillance system by acquiring administrative statistics from departments and agencies such as AMS, which have a role in injury prevention and management. |
| | <ul style="list-style-type: none"> • (2B) Strengthen the existing injury surveillance system to make it useful and sustainable | [Action 7] By conducting in-depth analysis on existing and updated data collected from surveys, strengthen understanding of the pattern and trend of injuries | <ul style="list-style-type: none"> • DH | Starting from 2015, in-depth analysis and interpretation of injury data will be conducted, and by 2016, articles will be published to reach different target audiences. |
| | <ul style="list-style-type: none"> • (2C) Promote research of feasibility, efficiency and cost-effectiveness of interventions to prevent injuries | [Action 8] Encourage more research on the four major types of injuries identified (i.e. sports injuries, falls, domestic injuries other than falls and drowning) | <ul style="list-style-type: none"> • DH • Other relevant Government departments/ bureau | The target is to designate the four major types of injuries in 2015 as thematic priorities for funding sources and promote interest in such research topics through forum/ workshop. |
| (3) Strengthen partnership and foster engagement of all relevant stakeholders | <ul style="list-style-type: none"> • (3A) To work with government bureaux/ departments, other health promotion partners, NGOs, schools, employees and employers of different industries to develop and implement measures that are sensitive to the needs of the public in achieving prevention of injuries | [Action 9] Support schools to strengthen injury prevention through voluntary participation in health and safety programmes covering school policy, injury surveillance, first aid training, staff development, student education, warm-up exercise before sports and parental engagement, with a long term goal to facilitate the implementation of EDB's Healthy School Policy | <ul style="list-style-type: none"> • EDB • DH | The component of injury surveillance (Action 5) will be introduced in pilot schools in 2015 followed by targeted actions in response to injury patterns specific to each school. Continued support from EDB will be enlisted to roll out a range of injury prevention actions in schools in the 2016/17 year and beyond. |
| | | [Action 10] Collaborate with Leisure and Cultural Services Department (LCSD) to strengthen sports injury awareness, surveillance and prevention | <ul style="list-style-type: none"> • LCSD • DH | From 2015 onwards, DH will work with LCSD to explore tapping into injury-related administrative statistics of government sports amenities (e.g. sports centre, beach and swimming pool) for use as a proxy for conducting surveillance of sports injury. Input will also be provided to LCSD for conducting community based surveys to reveal the prevalence of sports injury to inform policies and actions that promote safe sport. |

3 Actions to strengthen prevention of unintentional injuries

| Strategic directions | Recommendations | Actions | Lead action parties | Targets and timeframe |
|--|---|--|--|--|
| | | [Action 11] Engage stakeholder groups (ranging from service providers to users) and raise their awareness on injury prevention and safety promotion through briefing(s), sharing session(s) or seminar(s) | <ul style="list-style-type: none"> • DH • NGOs | Seminars for health promotion partners and relevant target groups will be organised on a regular basis. The first seminar will be conducted for the launching of the plan in 2015. |
| (4) Build capacity and capability to prevent injuries | <ul style="list-style-type: none"> • (4A) Develop personal skills to adopt injury preventive measures through communication of evidence-based advice | [Action 12] Raise awareness and safety literacy of cyclists for them to adopt safe practices and protective gear while cycling | <ul style="list-style-type: none"> • Road Safety Council • DH • Academia • Other relevant Government departments | In anticipation of more injury reports arising from cycling as an increasingly popular activity, workshops organised by the Road Safety Council for primary and secondary schools will be enriched with elements on injury prevention and performance enhancement in 2015. |
| | | [Action 13] Institute community-wide education on interventions proven to be effective in injury prevention in high risk situations | <ul style="list-style-type: none"> • DH • Consumer Council • C&ED • NGOs | Starting from 2015, DH will review recommendations on product safety issued by various government departments and statutory bodies, and organise them for more targeted promotion under the 4 priority areas. |
| | | [Action 14] Promote knowledge-based interventions to PE teachers and coaches as a means to raise sports performance and prevent sports injuries using a train-the-trainer approach | <ul style="list-style-type: none"> • EDB • LCSD • DH • Academia | In 2015, DH will work with EDB and LCSD to enrich training content for PE teachers and coaches with the focus on sports injury prevention. The target is to incorporate relevant training content from 2016/17 onwards. |
| | <ul style="list-style-type: none"> • (4B) Strengthen community awareness and actions to prevent injuries | [Action 15] Produce teaching aids to strengthen safety awareness and promote injury prevention actions by staff and students. Content to be introduced should be tailored to students' academic needs | <ul style="list-style-type: none"> • EDB • DH • Other relevant Government departments | Teaching materials will be reviewed to target primary students' learning needs and disseminated for teachers' use from 2016/17 onwards. |
| (5) Ensure a health sector that is responsive to the NCD challenges and to improve the healthcare system | <ul style="list-style-type: none"> • (5A) Engage healthcare professionals in promoting messages and practices that prevent injuries and identifying and managing at-risk groups | [Action 16] Engage primary care providers in dissemination of injury prevention information to increase the accessibility of at-risk groups to community support | <ul style="list-style-type: none"> • DH • Professional bodies • NGOs | Starting from 2015, DH will liaise with primary care providers and NGOs to enhance access of the public to community support services that aim to prevent and reduce elderly fall. |



4

Making it happen





4. Making it happen

- 4.1 To take forward this Action Plan, DH needs to actively engage in dialogue and collaborative partnerships with NGOs and community stakeholders. DH also needs to communicate the purpose, content, progress and achievements of the Action Plan as an effective means of mobilising inter-sectoral and cross-disciplinary support. Adopting the health leadership role, the Government stands ready to provide people with information on injury prevention and work closely with all sectors to create supportive environments for people to make healthy choices for themselves and their families.
- 4.2 The NCD challenge ahead is greater than ever. The WGI does not underestimate potential barriers, difficulties and challenges. Notwithstanding the above, we recognise active participation by everyone in the community is a major key to success. By working together, each of us can make Hong Kong a safer and healthier place to live.





Annexes

Annex 1

Membership of Working Group on Injuries

Chairman

Mr Patrick MA Ching-hang, BBS, JP

Vice Chairman

Dr LAM Ping-yan, JP

Department of Health (February 2012 to June 2012)

Dr Constance CHAN Hon-ye, JP

Department of Health (since June 2012)

Members

Dr Charles CHAN Ching-hai

Dr Peter CHAN Hung-chiu

Dr CHOW Chun-bong, BBS, JP

Prof Sian GRIFFITHS, OBE, JP

Ms Angie LAI Fung-ye, MH

Mr LIU Ah-chuen, MH

Mr NG Sze-fuk, GBS, SBS, JP

Dr Kathleen SO Pik-han, BBS, JP

Dr Patrick YUNG Shu-hang

Ex-officio Members

| | |
|------------------------------|--|
| Dr Thomas TSANG Ho-fai, JP | Department of Health (February 2012 to December 2012) |
| Dr LEUNG Ting-hung, JP | Department of Health (since December 2012) |
| Mr Victor HO Chun-ip | Education Bureau (since November 2013) |
| Mr KONG Man-keung | Hong Kong Police Force (February 2012 to April 2013) |
| Mr Dicky LAU Cheng-fung | Hong Kong Police Force (since November 2013) |
| Mr TSO Sing-hin, JP | Labour Department (February 2012 to September 2012) |
| Mr LI Chi-leung | Labour Department (since November 2012) |
| Miss Olivia CHAN Yeuk-oi, JP | Leisure and Cultural Services Department (November 2013 to November 2014) |
| Mr Richard WONG Tat-ming | Leisure and Cultural Services Department (since November 2014) |
| Ms Caran WONG Ka-wing | Social Welfare Department (February 2012 to August 2012) |
| Mr FUNG Man-chung | Social Welfare Department (since November 2012) |

Secretary

Dr LEUNG Ting-hung, JP
Department of Health
(February 2012 to December 2012)

Dr Regina CHING Cheuk-tuen, JP
Department of Health
(since December 2012)

Annex 2

Terms of reference of Working Group on Injuries

- (a) To assess the epidemiology, risk factors and socioeconomic determinants of injuries among the local population;
- (b) To make recommendations on the health improvement needs of the local population in relation to the prevention of injuries;
- (c) To review local and international good practices and intervention strategies to prevent injuries; and
- (d) To make recommendations on the development, implementation and evaluation of a plan of action for the prevention of injuries in Hong Kong.

Annex 3

Discussion topics in meetings of the Working Group on Injuries

| | Date | Topics |
|----------------|------------------|--|
| First meeting | 6 February 2012 | <p>Global Development of Injury Prevention (WGI Paper No. 01/2012)</p> <ul style="list-style-type: none"> • Definition and Classification of Injuries • Global Disease Burden of Injuries • World Health Organization's Commitment on Injuries • Overseas experience and scientifically-proven measures for injury prevention <p>Local Situation of Injuries (WGI Paper No. 02/2012)</p> <ul style="list-style-type: none"> • Epidemiology and Disease burden • Data collection and injury surveillance • Local situation of health promotion for major types of injuries |
| Second meeting | 7 January 2013 | <p>Strengthening Injury Prevention in Hong Kong (WGI Paper No. 03/2013)</p> <ul style="list-style-type: none"> • Principles to guide the work of WGI • Identification of priority areas • Two Pillars in injury prevention |
| Third meeting | 29 November 2013 | <p>Recommendations to Strengthen Injury Prevention in Hong Kong (WGI Paper No. 05/2013)</p> |
| Fourth meeting | 24 June 2014 | <p>Action Plan to Strengthen Injury Prevention in Hong Kong (WGI Paper No. 06/2014)</p> |

