World Health Organization

GLOBAL FORUM ON TRAUMA CARE

Rio de Janeiro, 28-29 October, 2009

Meeting report

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1. Summary

Injury causes 5.8 million deaths per year, over 90% in low- and middle-income countries. It also causes a significant amount of disability and economic loss. Much of this burden could be decreased by improvements in care of the injured (trauma care). In order to promote such improvements globally, over 100 trauma care leaders from 39 countries from all WHO regions met at the Global Forum on Trauma Care in Rio de Janeiro, Brazil on 28 - 30 October, 2009. Among these were 12 presidents or other officers from international professional societies, as well as 30 officers from national level organizations. Participants sought to develop a strategy to promote greater political commitment to affordable and sustainable improvements in trauma care. One of the major items of consensus among the participants was the need for a global network or alliance that would help to unite the different groups involved in the field towards a common goal. There was likewise a strong consensus that WHO should lead this effort. This meeting report briefly summarizes the discussions that occurred at the Global Forum on Trauma Care and the next steps to be taken.

Acknowledgements

The World Health Organization gratefully acknowledges the political, financial, and logistical support received for the Global Forum on Trauma Care from: the AO Foundation, the Bone and Joint Decade (BJD), the Brazil Country Office of the PanAmerican Health Organization / World Health Organization, the Brazilian Association for Intensive Care Medicine, the Brazilian Society for Orthopaedics and Traumatology, the European Federation of Orthopaedics and Traumatology (EFORT), the Government of the City of Rio de Janeiro, the Government of the State of Rio de Janeiro, and the Ministry of Health of Brazil.

2. Background and Objectives

GLOBAL FORUM ON TRAUMA CARE
28 - 29 October, 2009

Many people are working hard, often against considerable difficulties, creating innovative solutions and making progress in improving trauma care in their own countries. Their efforts received notable support in 2007, when the World Health Assembly (WHA) adopted Resolution 60.22 on trauma and emergency care services, calling for increased attention to the issue by Member States and the World Health Organization (WHO). This resolution recommended several concrete steps that could be taken by Member States and WHO, that would help to strengthen trauma care services globally. Despite these efforts, much still remains to be done to strengthen trauma care, especially in low-income and middle-income countries.

In order to better promote the low-cost and sustainable improvements recommended by WHA Resolution 60.22 and to promote improved trauma care in countries everywhere, WHO and other partners are collaborating to increase advocacy for trauma care globally. Thus, WHO is convening the Global Forum on Trauma Care in Rio de Janeiro, Brazil on 28 - 29 October, 2009. The Forum is being held with the support of the State Government of Rio de Janeiro and the Ministry of Health of Brazil and with local coordination by the PanAmerican Health Organization / WHO Brazil Country Office. The goals of this Forum are to achieve greater attention to affordable and sustainable improvements in trauma care services globally by promoting greater uptake of the recommendations of WHA Resolution 60.22. In particular, the participants will meet to develop ways in which to mobilize decision makers in countries worldwide. This Forum will be the start of a broader collaborative process to create an expanded network for trauma care advocacy.

OBJECTIVES OF THE FORUM:

1. Agree on a set of *priorities and goals* around which to advocate in the future, so that trauma care advocates globally can give similar messages on sustainable and affordable improvements in trauma care that are needed.
2. Develop an *agenda for action* on which participants and their organizations agree to work together over the next 10 years.
3. Develop *key messages and plans for their dissemination*. These messages will seek to mobilize decision makers in countries worldwide to enact sustainable and affordable improvements in trauma care.
4. Develop a *consensus statement*, summarizing the decisions reached in the meeting.
5. Begin work on creating *tools for advocacy* (e.g. draft press releases, talking points for dealing with governments and the media, fact sheets). These tools will be discussed during the forum and will be developed and finalized during the follow up period.
6. *Global network for advocacy.* An important output of the forum and the broader collaborative follow-up process will be an expanded network of people and organizations active with trauma care advocacy in their countries and regions. This will build on existing networks, such as those of professional societies. This expanded network will be responsible for delivering the key messages and thus promoting the priorities agreed upon in the Forum.

3. Details of the Forum

The Global Forum was opened by Dr. Jose Gomes Temporao, Minister of Health of Brazil. Others who spoke at the opening ceremony included Eugenia Rodrigues (PAHO), Jose Luiz Gomes do Amaral (Brazilian Medical Association and World Medical Association), Wahid Alkharusi (Ministry of Health of Oman and BJD), Etienne Krug (WHO), Hans Dohmann (City of Rio de Janeiro), and Sergio Cabral (State of Rio de Janeiro).

Dr. Krug, Director of the Department of Violence and Injury Prevention and Disability (VIP), WHO HQ, Geneva, welcomed the participants and oriented them as to the purpose and plan for the meeting. Dr. Marcos Musafir, local arrangements coordinator, reviewed logistical issues.

Dr. Charles Mock of WHO VIP gave an overview of the status of trauma care globally, including the gaps to be addressed. He also explained the anticipated role of the Global Forum on Trauma Care in increasing political commitment for trauma care globally.

Dr. Jeremy Shiffman, Professor of Political Science from Syracuse University, gave an analysis of issues that determine the political priority given to particular health problems, whether as part of the global health agenda or national health agendas.

The major part of the meeting consisted of small group discussions to brainstorm on specific aspects of ways in which to increase the political commitment given to trauma care globally. The small group discussions were each then followed by plenary presentations by each of the small groups. For each topic, general discussion among the plenary participants followed. The topics discussed by the small groups included:

- Brainstorm on ways to increase the political profile of trauma care.
- Define a set of priorities and goals
- Define key messages and plans for their dissemination
- Develop tools for advocacy
- Setting an agenda for action
- Developing a global network for advocacy

Further details of what was discussed on each topic are included in the agenda (Appendix A). The list of participants is included as Appendix B. In depth recording of the discussion in each small group is included in Appendix C.

4. Take Home Points from Group and Plenary Discussions

The major take home points derived from the small group discussions were:

1. Meeting participants related well to the political analysis provided by Dr. Shiffman and felt that the various groups involved with care of the injured needed to become more united and to develop common messages with which they could collectively advocate.
2. There was general consensus that the main objectives for collective advocacy should entail the elements highlighted in WHA Resolution 60.22 (Appendix D).
3. Concise key messages still need to be defined, especially those that will resonate with the lay public and policy makers. A preliminary set of key messages included that every injured person should have:
    i. Basic life saving care in the field and rapid transport to a site of definitive care.
    ii. Access to adequate, timely, essential care that is life or limb saving at hospitals and clinics.
    iii. Access to adequate, essential rehabilitation services for those with disabilities resulting from their injuries.

    (*These messages will need to be refined*. Also, the exact implications of the messages will vary with location. However, as general principles, these messages were felt to be sufficiently broad to encompass most care needed for the injured, to be understandable by the lay public, and to have the possibility of being taken up by advocates from within the lay public and the policy maker community).
4. There was a general feeling that the time was not quite right for developing tools for advocacy (such as draft press releases, talking points for dealing with governments and the media, fact sheets, etc.) and that other components of follow up from the Global Forum should be addressed first.
5. There was wide consensus that there should be a network or alliance established, including the institutions and organizations represented at the Global Forum as well others involved with the field globally. This network would help to advocate for needed improvements worldwide and would help to finalize and advance the above items, such as defining and promoting preliminary key messages.
6. There was some discussion as to the name of the network / alliance and the field of endeavor it should encompass. Some participants felt that it should be restricted to trauma care and only address injured patients. Some participants felt that it should encompass other emergency care services. Both groups felt that the need to address and advocate for rehabilitation services for injured persons with disabilities would be covered by their approach. Several participants pointed out that the lay public would probably not relate well to titles like "trauma care" or "trauma and emergency care services". The name "Global Alliance for Care of the Injured" was suggested as a name that would be well understood by the public. During the plenary discussion, many felt that this title was suitable. Although some preferred to keep with their original titles, there was wide consensus that almost everyone could live with a title utilizing the phrase "care of the injured." Advocacy work along these lines will look for ways to expand more horizontally, encompassing and addressing more broad improvements in care of persons with other emergency conditions. Likewise, the title "Global Alliance for Care of the Injured" does not in any way imply that this group would advocate that prehospital care agencies or hospitals be created only for care of the injured and ignoring those with other emergency conditions. Finally, such an

alliance would be primarily focused on treatment services (secondary and tertiary prevention). It would look for opportunities to promote primary prevention when possible, but that would not be its main mission.

7. Although there was debate on the various points above, participants unanimously requested WHO to take the lead in developing this global alliance.

5. The Way Forward

Given the request of the meeting participants that WHO should take the lead in developing a Global Alliance for Care of the Injured, staff from WHO's Department of Violence and Injury Prevention and Disability (VIP) will explore internally within WHO the steps needed to set up such an alliance. We will seek to identify the most straightforward way among the various possible options, as creation of some types of alliances involve the need for World Health Assembly approval.

Specific items that will need to be addressed in this development process are:

- The exact functions the Alliance would undertake.
- What its legal status would be, if any.
- How individual institutions and organizations would become participants.
- What would the roles of WHO be.
- Funding. Although it is expected that the Alliance would function on low resources, there would still need to be some resources. We will need to explore where these would come from.

Participants in the Global Forum on Trauma Care will be updated as developments occur.

Appendix A.

GLOBAL FORUM ON TRAUMA CARE
Rio de Janeiro, Brazil, 28-29 October 2009

AGENDA

Day ONE: 28 October 2009

08:00 - 08:30 Registration

08:30 - 08:50 Welcoming and orientation to work plan for meeting
Etienne Krug, Violence and Injury Prevention and Disability, WHO

08:50 - 08:55 Meeting logistics
Marcos Musafir, Local Organizing Committee, Rio de Janeiro, Brazil

08:55 - 09:15 Overview of status of trauma care globally and gaps to be addressed
Charles Mock, Violence and Injury Prevention and Disability, WHO

09:15 - 09:45 Analysis of how to get an issue higher on the global health agenda
Jeremy Shiffman, Syracuse University, USA

09:45 - 11:00 Small group discussions: **Brainstorming on ways to increase the political profile of trauma care.** *Objectives:* To develop ways to utilize the determinants of political priority in order to position trauma care higher on the global health agenda:
(a) Actor power: how can we increase the cohesion and strength of the individuals and organisations concerned with trauma care.
(b) Ideas: how can we better agree among ourselves on the solutions to the problem and portray these solutions effectively to external audiences, especially political leaders who control resources.
(c) Political contexts: how can we create and make use of "policy windows" - political moments when conditions align favourably and enable advocates to influence decision makers.

11:00 - 11:10 Coffee Break

11:10 - 12:00 Opening Ceremony
Opening: *Jose Gomes Temporão, Minister of Health of Brazil*
Welcoming speeches:
Sergio Cabral, Governor of State of Rio de Janeiro
Eduardo Paes, Mayor of Rio de Janeiro
Etienne Krug, Violence and Injury Prevention and Disability, WHO
Lars Lidgren, Bone and Joint Decade

12:00 - 13:45 Lunch

13:45 - 14:45 Plenary discussion of results of working groups

14:45 - 16:00 Small group discussions: **Define set of priorities and goals.** *Objectives:* Based on the priorities and goals highlighted in WHA Resolution 60.22, Forum participants will agree on a set of priorities and goals around which to advocate in the future. These will consist of a set of priorities and goals that will resonate with decision makers and will be the foundation for effective advocacy to increase the attention given to trauma care globally.

16:00 - 16:15 Coffee Break

16:15 - 17:15 Plenary discussion of results of working groups

DAY TWO: 29 October 2009

08:30 - 09:00 Summary of discussions from previous day

09:00 - 10:30 Small group discussions: **Define key messages and plans for their dissemination.** *Objectives:* Develop a set of highly effective messages that can be disseminated in different locations and through different channels worldwide to achieve maximum effect. These messages will seek to mobilize decision makers in countries worldwide to enact affordable and sustainable improvements in trauma care.

Small group discussions: **Develop tools for advocacy.** *Objectives:* To initiate the creation of a set of tools for advocacy. These will include a variety of items, such as draft press releases; talking points for dealing with governments and the media; fact sheets; and other items to be decided upon. During the Forum, drafts of such tools for advocacy will be started. They will be further developed and finalized during the follow-up process after the meeting.

10:30 - 10:45 Coffee Break

10:45 - 11:45 Plenary discussion of results of working groups

11:45 - 12:30 Orientation to final small group discussions

12:30 - 13:45 Lunch

13:45 - 15:15 Small group discussions: **Setting an agenda for action.** *Objectives:* Develop an agenda for action on which Forum participants will agree to work together over the next ten years. This will include initiatives to get greater attention to trauma care globally and concrete actions to achieve the above goals and priorities.

Small group discussions: **Developing a global network for advocacy.** *Objectives:* Decide the form in which such a global network for trauma care advocacy could be created, who its members should be, and how it should communicate and function.

15:15 - 15:30 Coffee Break

15:30 - 16:15 Plenary discussion of results of working groups

16:15 - 16:45 Conclusions
Assignment of follow up activities
Adopt Consensus Statement

16:45 - 17:00 Closing

Appendix B. Participant list

SURNAME	NAME	POSITION	ORGANIZATION	COUNTRY
ABRAHÃO	José Carlos	IHF President	International Hospital Federation	Rio de Janeiro, Brazil
ALBORNOZ	Consuelo		AOTrauma Latin America	Colômbia
AL KHARUSI	Wahid	Ambassador ,The Foreign Ministry	Bone and Joint Decade	Muscat, Sultanate de Oman
ALVAREZ	Martin Ernesto Adrian	MoH	National Rosales Hospital	San Salvador, El Salvador
ARAFAT	Raed	Undersecretary of State	Ministry of Health	Bucharest, Romania
BALDY DOS REIS	Fernando	Chief of Traumatology	SÃO/ UNIFESP	São Paulo, Brazil
BASSO	Armando	President	Mundial Federation of Neurosurgery Societies	Buenos Aires, Argentina
BODIWALA	Gautam	President	International Federation for Emergency Medicine	Leicester, England
BRAGA	Lúcia	President	Sarah Network of Neurorehabilitation Hospitals	Brasilia, Brazil

BREIGERON	Ricardo	Director SBAIT	Brazilian Society for Trauma Integrated Care	Porto Alegre, Brazil
CANETTI	Marcelo	Comandante	Emergency Group	Rio de Janeiro, Brazil
CARVALHO	Frederico	Director AMIB	Brazilian Association Intensive Medicine	São Paulo, Brazil
CASTRO CALLE	Fernando	Professor	University of Cuenca, Medicine School - MoH	Cuenca, Ecuador
CHADBUNCHACHAI	Witaya	Director, Trauma and Critical Care Center - MoH	Khon Kaen Hospital	Khon Kaen, Thailand
CHAROENCHEEWAKUL	Chatree	Director	Emergency Medical Institute of Thailand (EMIT)	Bangkok,Thailand
CHHUOY	Meng	Head of Critical Care Ward	Calmette Hospital	Phonm Penh, Cambodia
CHICHOM MEFIRE	Alain	Chief of Service of Surgery	Regional University Teaching Hospital - MoH	Yaoundé, Cameroon
CONCEIÇÃO	Mario	Coordinator	Social Forum	Salvador, Brazil
CORREA	João Pedro	Director	JPC Communication	Curitiba, Brasil
CURCI	Michael	Pediatric Surgeon	Maine Medical Center	Portland, USA

CYMET	Jose	BJD Network	Latin American Society of Orthopaedic and Traumatology	Mexico City, Mexico
DANGAA	Baigalmaa	Deputy Director of Public Health Policy Coordination Department	Ministry of Health	Ulaanbaatar, Mongolia
D'AVILA	Arlindo	Director	Brazilian Society of Neurosurgery	São Paulo, Brazil
DAVOLI	Enrico	Programme Manager, Emergency Medical Services	World Health Organization	Barcelona, Spain
DE WINDT	Paul	President	Latin American Federation for Traumatology and Orthopaedic	Curaçao, Curaçao
DIMITROV	Boris	Adviser	Ministry of Health	Bishkek, Kyrgyzstan
EISENMANN-KLEIN	Marita	General Secretary	International Confederation for Plastic Reconstructive Surgery	Regensburg, Germany
ELLAWALA	Ranjith	Consultant Surgeon MoH	The National Hospital of Sri Lanka	Pannipitiya, Sri Lanka
ESCOBAR	Andres RUBIANO	President	Colombian Prehospital National Association	Neiva, Colombia
FERRAZ	Edmundo	President	Brazilian Surgeon School	Recife, Brazil
FRANCO	Jose Sergio	Delegate	SICOT : International Society of Orthopaedic Surgery and Traumatology	Rio de Janeiro, Brazil

FULLAN	Tom	Ambassador	The Bone and Joint Decade	Winnipeg, Canada
GAVINA	Rodrigo	Director	Rede D'Or Hospitals	Rio de Janeiro, Brazil
GOMES DO AMARAL	José Luiz	President	Brazilian and World Medical Association	São Paulo, Brazil
GONZÁLEZ-ECHEVERRI	Germán	Epidemiologist - MoH	Antioquia University -Public Health National School	Envigado, Colombia
GOOSEN	Jacques	Head, Johannesburg Hospital Trauma Unit	University of the Witwatersrand	Johannesburg, South Africa
GROBLER	René	Trauma Unit Manager	Life Healthcare	Pretoria, South Africa
GRUEN	Russell	Director	National Trauma Research Institute, The Alfred Hospital	Melbourne, Australia
HARO	Gonzalo	Consultant - MoH	Equador	Quito, Equador
HENNING	Kelly	Director	Bloomberg Family Foundation	New York, USA
HERNANDEZ	Adrian	Manager	Latin American Federation of Traumatology	Bogotá, Colombia
HERNANDEZ GALVEZ	Martha	President	Ecuatorian Society of Orthopaedic and Traumatology	Quito, Ecuador

HERWIG	Damian		AO Foundation	Davos, Switzerland
HOFFMEYER	Pierre	Academic Director, Universities Hospitals of Geneva	European Federation of Orthopaedic and Traumatology	Geneva, Switzerland
HUNT	Richard	Director /Division of Injury Response	Centers for Disease Control and Prevention - CDC	Atlanta, USA
ISLAM	Shariful	Director of Trauma Care	MoH	Bangladesh
JOSHIPURA	Majul	Director	Academy of Traumatology	Ahmedabad, India
KEYES	Christine	Associate Director of Global Health	Emory University Department of Emergency Medicine	Atlanta, USA
KOBUSINGYE	Olive	Chief of Trauma	MoH	Kampala, Uganda
KRUG	Etienne	Director, Department of Violence and Injury Prevention and Disability	World Health Organization	Geneva, Switzerland
LASHOHER	Angela	Medical Officer	WHO - Patient Safety Program	Geneva, Switzerland
LOBO	Paulo	Consultant for Trauma	MoH	Brasilia, Brazil
LOURENÇO	Paulo Barbosa	Director	Brazilian Society of Traumatology	Rio de Janeiro, Brazil

MACHADO	Antonio	Regional Director	Spine - AO Foundation Latin America	São Paulo, Brazil
MALDONADO BANKS	Mercedes	Director of Programa National Control of Accidents and Trauma	Ministery of Public Health and Social Care	Asunción, Paraguay
MARROQUÍN	María Angela	President, Director ICN	Nursery National Association	San Salvador, El Salvador
MARTIN	Sara	COO	The Bone and Joint Decade	Antwerp, Belgium
MASINI	Marcos	Regional Advisor	School of Medicine of Planalto Central	Brasília, Brazil
MEIRELLES	Sergio	Director	Brazilian Society of Vascular Surgery	Rio de Janeiro, Brazil
MERCADANTE	Marcelo	President	Brazilian Society of Traumatology and Orthopaedic	São Paulo, Brazil
MESQUITA	Gerardo	Secretary	Health Secretary of State and State Comittee of Urgence and Emergency	Teresina, Brazil
MIRANDA	Luiz Otávio	Advisor	Department of Transit	Belém, Brazil
MOCK	Charles	Medical Officer, Department of Violence and Injury Prevention and Disability	World Health Organization	Geneva, Switzerland
MONTEIRO	Flávio	General Coordinator	Hospital of State of Rio de Janeiro	Rio de Janeiro, Brazil

MUGENZI	Dominique	MoH Advisor	Kigali University Teaching Hospital	Kigali, Rwanda
MUSAFIR	Marcos	Orthopedic Surgery		Rio de Janeiro, Brazil
NASTOV	Nebojsa	President	EMS Reform Commission	Skopje, R. Macedonia
NGUYEN	Thai Son	Deputy Director	Hanoi Saint-Paul Hospital	Hanoi, Vietnam
OGAWA	Hisashi	Regional Adviser in Healthy Settings and Environment	World Health Organization	Manila, Philippines
PADILHA	Jose Alfredo	Diretor	Clinic Surgery of Souza Aguiar Hospital	Rio de Janeiro, Brazil
PESSOA	Roberto Frota	President	Trauma Group of Rio de Janeiro, Miguel Couto Hospital	Rio de Janeiro, Brazil
PLOTOWSKI	Luiz Mauricio	Superintendent	SESDEC	Rio de Janeiro, Brazil
POGETTI	Renato	Regional Coordinator	American College of Surgeons	São Paulo, Brazil
PUYANA	Juan Carlos	Director	Innovative Medical & Information Technology Center	
RACY	Fabio Ford	Director	ABRAMET	São Paulo, Brazil

RAZZAK	Junaid	Chairman	Department of Emergency Medicine Aga Khan University	Karachi, Pakistan
REA NETO	Alvaro	President	Intensive Medicine Brazilian Association	Curitiba, Brasil
RESENDE	Ederlon	Director	Brazilian Association Intensive Medicine	São Paulo, Brazil
RESTREPO	Nicolas	Director	SCCOT - Colombian Society of Traumatology and Orthopaedic Surgery	Bogotá, Colombia
REUNGJUI	Potipong	Chief, Trauma and Surgical Critical Care Unit	Khon Kaen Hospital	Khon Kaen, Thailand
RISSA	Carlos Arreola	Director	Trauma Surgeon School of Medicine	Mexico City, Mexico
RODRIGUES	Eugenia	Regional Adviser on Road Safety in Washington	Pan American Health Organization	Washington DC, USA
ROY	Nobhojit	Head, Department of Surgery	BARC Hospital	Mumbai, India
RUIZ PITANO	Marco	Consultant MoH	Complejohospitalario Metropolitano - Caja Seguro Social	Panama City, Panama
SCHMUCKER	Uli	Director	Trauma Research Center	Greifswald, Germany
SEGURA	Julio	Director	Peruvianf Orthopaedics and Traumatology Association	Lima, Peru

SHIFFMAN	Jeremy	Associate Professor of Public Administration	Syracuse University	Syracuse, USA
SILVA	Jorge Santos	Director	Brazilian Society of Traumatology and Orthopaedic	São Paulo, Brazil
SILVEIRA	Lucia	Superintendent SMS	Urgence and Emergency at Rio de Janeiro	Rio de Janeiro, Brazil
SMINKEY	Laura	Communications Officer	Dept of Violence and Injury Prevention and Disability, World Health Organization	Geneva, Switzerland
SOLAGBERU	Babatunde	Consultant MoH	Lagos State University Teaching Hospital	Lagos, Nigeria
STENGEL	Dirk	Director of Research	The Bone and Joint Decade	Berlin, Germany
STEVENS	Kent	Department of Surgery	Johns Hopkins Hospital	Baltimore, USA
SUAREZ	Fernando	Superintendent	Pre Hospital Emergency	Rio de Janeiro, Brazil
THORNGREN	Karl	Presdident	EFORT - European Federation of Orthopaedics and Traumatology	Stocolm, Sweden
TRAFTON	Peter	Brown University - Director	Foundation AO Trauma	Providence, USA
TURNER	James	Patient Safety Program	World Health Organization	Geneva, Switzerland

VANE	Luis Antonio	Director	Anestesiology Brazilian Society	São Paulo, Brazil
VARGHESE	Mathew	Head of Orthopaedics Department	St Stephen's Hospital	New Delhi, India
VELASCO	Jose GARCIA	President	Panamerican Society of Trauma	Ciudad Bolivar, Venezuela
VILLAFRANCA	Jorge	General Secretary	SLAOT	San Jose, Costa Rica
VILLALOBOS	Enrique	Disaster Consultant	MoH	Mexico City, Mexico
WORA-URAI	Nopadol	President	Royal College of Surgeons	Bangkok, Thailand
YAN	Jun	Director, Division of Mental Health and Injury Control	Ministry of Health	Beijing, P.R. China
ZAKARIAH	Ahmed	Director	Ghana Ambulance Service	Accra, Ghana

Appendix C: Summary of small group discussions

Session 1: Brainstorming on ways to increase the political profile of trauma care:

Objectives: To develop ways to utilize the determinants of political priority in order to position trauma care higher on the global health agenda:

(a) Actor power: how can we increase the cohesion and strength of the individuals and organizations concerned with trauma care.
(b) Ideas: how can we better agree among ourselves on the solutions to the problem and portray these solutions effectively to external audiences, especially political leaders who control resources.
(c) Political contexts: how can we create and make use of "policy windows" - political moments when conditions align favourably and enable advocates to influence decision makers.

Group one*:* In discussing actor power the group first pointed out the need to define the actors, in particular politicians around the time of elections, and the need for those politicians to be public in their support for trauma care. In order to interest politicians it was discussed that it would be important to emphasize the victims of trauma. The group said that it would be important to get the right actors together for meetings at the local, regional and national level. At each level it would be important to have politicians, policy makers, media, health care workers, NGO's and victims involved in the discussion. Regarding ideas and solutions the point was raised that it may be helpful to give individual states tools for them to use in improving trauma care. The point was raised that trauma care involves many different groups so it would be important to establish coalitions, which may include the national health security office and trauma/medical associations each of which would have a focal point. The goal of this coalition would be to encourage dialogue not create a bureaucratic body. In the creation of a coalition across groups including medical specialties involved in trauma care it will be important to recognize that trauma usually disproportionately affects lower socio-economic groups. Exposing the media to data collected on trauma care will be important. The entire group agreed that trauma prevention is important to focus on. Engaging victims can be powerful way to engage the media. It will also be important to get the media to have the right message across. In the policy context it will be important to say the right messages, such as the importance of prevention, rescue services and the importance of opening more trauma centres. We need simpler less expensive measures to advocate for during the policy window. There was also some discussion around how best to recognize when a policy window exists.

Group two: The discussion of actor power involved several key items: improving the visibility of trauma care, WHO acting as a leading agency, the formation of an international alliance or champion organization, creating a pool of international spokespersons , media support, and global societies/federations of trauma care specialities. In the discussion on specific ideas the group considered the following key points: measurable global indictor/index, involve other ministries, document impact of high or low energy trauma, document socioeconomic impact, and to draft and solicit signatures for a "Rio Declaration of Trauma Care". To address the final point of the political context the group thought the following would be important to coordinate with other high profile global programmes (Road Safety, MDG) and that it would be important to lobby together with strong global partnerships even involving some private sector companies such as oil companies & the automobile industry. The group also thought it would be important to write a UN Resolution on Trauma Care.

Group three: This group felt it was important to first define the trauma disease profile. Trauma and injury are concepts which are misperceived and their burden is generally under-estimated in debates for prevention and treatment. The group felt that a database should be built upon existing data which would enable comparison with other diseases and in different settings. There are consistent inequities in the delivery of trauma care throughout the world therefore there is a need to find a common denominator which might spark a global action (with local adjustment). The group felt that research

on gaps in prevention measures and precise requirements for basic trauma care at a national and global level would be important. Providing this evidence would help politicians to act. To foster and encourage a global community on trauma care we need to expand beyond medical community and impress upon people that trauma (can) affect everyone, directly or indirectly, cross-cutting economic-social-gender status. To do this it would be helpful to include victims & their families. The group felt that the key solutions lie in education of general population, emergency responder, community leaders, medical staff etc.
But the group was less clear on what kind of education that would entail and what the precise messages would be. The group's take home messages were the following: 1 – define the disease profile, 2 – assess needs and gaps in trauma care at local level, 3 – research on gaps in national legislations, 4 – create a global community that expands beyond medical community, and 5 - define a clear solution with education as a key component.

Group four: The point was raised that could a national body in each country lead the effort, for example, a representative from the global forum who acts as the liaison between the health care associations/providers and the policy makers that could unify the message.
We need to collect data to support the message that trauma is an urgent high priority. We need to provide comparable data. In order to communicate as a community we need a unifying body or mechanism. A web based community was suggested. The importance of defining the target was also discussed– is it government, health care communities, the public. Other suggestions were to make forum permanent so we can continue this focus and make efforts sustainable and to target the policy advisor to the health minister as a link between the public, the health care community, and the government. The discussion on specific ideas revolved around the need to have a common definition of the problem and to develop a unified message with a common priority or intervention. The group also discussed how do to attract markets and industry to the issue, including media and press. In the discussion on the political context the group felt that currently wars are creating public attention for trauma and that we could use the world data on road traffic safety to focus attention on trauma. The group also suggested learning from the H1N1 experience to translate the importance of emergency services in identifying and treating H1N1 and to use this moment to show how emergency services are crucial to issues other than trauma.

Group five: In order to increase actor power the group felt we should develop a single forum incorporating all stakeholders across the spectrum of trauma and develop a single roadmap to avoid fragmentation, and train spokespeople accordingly. We should also obtain representation at forums of decision-makers. We should have a single slogan and "prevent it, treat it, and rehabilitate it" "do the right thing for the right patient by the right people in the right facility in the right time" were suggested. The group discussed having a single, urgent system of alarm to ensure rapid access to emergency medical services and rapid intervention and transfer to the most appropriate facility. Other ideas that were highlighted as important were advanced organ support to limit potentially fatal systemic complications and rehabilitation to the best possible previous function and re-integration into society. An audit to identify preventable errors, cost-benefit of systems, and the most appropriate allocation of resources was suggested. Education and outreach to all affected and involved sectors, including public internal leadership development were also highlighted. In the political context the group felt it was important to learn how to manage the media to convey our message and mobilize public opinion. Identifying and using favourable events to promote a single prepared doctrine (sport, disaster, war) was also raised within the context of a de-politicized message of emergency and trauma care.
It was felt important to align with- and use global political goals and to enlarge trauma beyond healthcare as a public safety issue – disaster management, financial, justice, police, social security\support, business etc. Aligning with other disease–specific initiatives to obtain horizontal integration in healthcare systems was also felt to be important.

Session 2: Define set of priorities and goals.

Objectives: Based on the priorities and goals highlighted in WHA Resolution 60.22, Forum participants will agree on a set of priorities and goals around which to advocate in the future. These will consist of a set of priorities and goals that will resonate with decision makers and will be the foundation for effective advocacy to increase the attention given to trauma care globally.

Group one: The group first discussed some common goals, such as every injured individual should have access to/has a right to adequate/timely and effective trauma care that is life or limb saving. The group also discussed the challenges in defining global priorities because in order to be applicable to everyone, they must be very generic & may not be very useful. Specific objectives may not be applicable to everybody. The group suggested having a list of wants ready for when the Health Minister asks and that these should be important issues & backed up by data. The group outlined a priority setting framework that involved the following: incidence, burden, cause of preventable death +/- morbidity (supported by data), realistically achievable, that is supported by the Pre-hospital & Essential Trauma Care Guidelines. The group felt that the care priorities should be appropriate to the setting and should involve 3 levels of data complexity for basic, intermediate & advanced settings. In the group's discussion on the capacity building for trauma care there was a discussion that trauma should be done by people adequately trained to do trauma care. To accomplish this we would need training courses and continuing medical education. There was a discussion that capacity building in all aspects, including research, audit, use of data & quality improvement, injury scoring, and publishing results.

Group two: This group first discussed the pre-requisites which were the following: statistics, measurable parameters, a trauma system maturity index, and economic burden on the country. The group discussed the social impact of injury on families. The group discussed the actions that governments can take to improve trauma care, such as resource allocation, policy legislation, education, training , research, resource reallocation, and the development of Trauma System. Additional standards and avenues for care implementation include: Apex Agencies for Trauma Care involving professionals, Policy & Legislation, Trauma Care Legislation, Federal Vs State level, Development of New Cadre, Protocols for treatments, Education, Medical Education, Nursing & paramedic Education, Core Competency for all professionals handling trauma care
Research, Economics of Trauma Care and National Productivity and GNP, Advocacy, Global Economic Forum, World Bank, UN Assembly, and Lobbying Agencies.

Group three: This group felt that the injured patient's right to full and free access to timely and competent care included the following: 1 – COMMUNICATION: universal free number – dispatching transportation – counselling, 2 – TRANSPORTATION: coordinated public network established , 3 – AWARENESS: general population educated to basic behavior in emergency, 4 – STANDARDS: importance of clinical protocols (triage) \ essential resources list, 5 – EDUCATION: skills and competency building for medical \ para-medical community.

Group four: There was a discussion of the need to have a message. One suggested message is that we should use standard protocols/algorithms in pre-hospital and hospital settings that have proven to reduce mortality and morbidity. "Treat first what kills first" was suggested as a slogan. There was a discussion on the need for data to support the message. Trauma registries and QI data were suggested. The point was also raised that we should learn to speak the language of politicians. The following trauma priorities in each country were discussed as examples:

Mongolia: Improve collaboration and communication between stakeholders
Peru: Global Index
Cambodia: Finance the existing Health Policy and improve prehospital care services
Camaroon: Decrease prehospital mortality and increase use of prehospital care services especially in rural areas
Krygzstan: Identify targets for public education

Paraguay: Show public high cost of trauma care
Sri Lanka: Improve training of health care personnel, improve infrastructure and available resources
Germany: Ensure use of trauma standards and algorithms – ATLS and PHTLS
Canada – Start national hip fracture strategy

The group then discussed the need to have a unified message and global priority with a corresponding problem and solution statement. These two things need to be very simple and easy to understand with the priority being to make the following tangible:
1. Improve access – emergency access number, decrease transport time
2. Improve quality
3. Improve education/training – use standards like ATLS/PHTLS in prehospital and hospital settings
4. Improve data collection and analysis – institute trauma registries
5. Improve awareness
6. Improve collaboration (ie international mentoring)
7. Improve communication (between health care community and public, and amongst ourselves)

Group five: The group felt that a Global Forum for Trauma Care under the auspices of WHO should be created to ensure the following: coordination of activities of member organizations, advocating the inclusion of trauma and emergency care in national health services, formulating a priority list, ensuring a multi-disciplinary approach to trauma, ensuring external audit and review by region or country, and strengthening responses to major medical events (mass casualties). The group also felt that informing interested parties about the global and regional burden of trauma based on standardized data would be important. As would developing systems to analyze process of care and outcome by country and region to determine best practice, including the following: regionalization of care according to need and resources, indiscriminate access to care, alarm and communications, pre-hospital care, care in the emergency room, definitive care, including surgery and organ support, rehabilitation, continuous quality improvement. Education was also stressed to ensure that core competencies are taught from under-graduate level, to promote population-based low cost sustainable skills. Promoting adequate funding of trauma care as part of healthcare budget was thought to be important in addition to advocating for high-impact and low-cost trauma care practices.

Session 3: Define key messages and plans for their dissemination; develop tools for advocacy.

Objectives: Develop a set of highly effective messages that can be disseminated in different locations and through different channels worldwide to achieve maximum effect. These messages will seek to mobilize decision makers in countries worldwide to enact affordable and sustainable improvements in trauma care.
Objectives: To initiate the creation of a set of tools for advocacy. These will include a variety of items, such as draft press releases; talking points for dealing with governments and the media; fact sheets; and other items to be decided upon.

Group 1: Suggested messages were "Every injured individual should have access to/has a right to adequate/timely and effective trauma care that is life or limb saving". Participants in this group posed the question 'should we focus on quality of care and does this include care at the right time?' Another message was "Nine people die from injuries every minute.... Four could be saved. Support Trauma Care". Discussed amongst the group was the need for statements vs. messages and if statements were to be used, scientific background is essential. The participants asked whether using slogans would be beneficial and suggested utilizing emotion in these.

Group 2: Message characteristics should include: severity of problem (comparison), a solution statement, emotional resonance. One problem statement suggested was "Injury as a leading cause of preventable death, notably in children and the young population <44 years". Suggested solution

statements were "One third of deaths can be prevented", "Simple cost effective measures are available", "Right to care for vulnerable population".
The group thought that targeted public messages should be dramatic/strong, have emotional appeal, powerful impact globally, use simple language reinforcing the golden hour concept. Official messages should emphasize the significant economic burden, especially on the young population especially to parliamentarians and ministers. Suggested media tools to improve recognition include electronic media (tv/ radio/ web), the creation of online communities, newspapers, academic articles in medical journals and newsletters for the public audience. Within all media forms, using victim communities and families will add strength to the message.

Group 3: Suggestions included the following: "Injuries are one of the leading causes of death, and take more than 5 million lives every year", "Two million of those five million lives can be saved by improving trauma and emergency care", "Every person has the right to timely and effective trauma and emergency care", "Low-cost, cost-effective, sustainable interventions in trauma and emergency care are available", and "The community has an important role to play".

Group 4: The group suggested the introduction of trauma days to provide opportunity for media and government attention and may create a policy window. This could include a targeted multimedia campaign, using a face or a story to portray the message. Web related format focused on industry, other healthcare departments and individuals using the service from home, was also suggested. The use of public service/ commercial announcements was suggested. Incorporate trauma education into the basic curricula of both primary and medical teaching with the instigation of trauma conferences, encouraging intersectoral co-operation was suggested. Other tools suggested within healthcare included additional funding for trauma care, the introduction of a trauma registry if not already established and the development of an emergency care service.

Group 5: The group suggested "Timely, *effective, adequate, optimal*, trauma care saves lives". Participants emphasized the need to collect information, select the correct message and effectively disseminate it. The group thought it would be important to perform epidemiological data analysis and disseminate the results on the absolute number of mortalities due to trauma in comparison to other diseases, the distribution of place of mortality, the in- hospital mortality compared to other diseases, and the distribution of cause of injury by country. The group thought it would be important to disseminate the results of a resource utilization data analysis (Trauma registry) on response times & total pre-hospital times and resources utilization, ED Resources utilization, the proportion of trauma death as part of overall number of deaths, the proportion ICU beds, the proportion of ward beds, the proportion blood/ blood products, ICU days, and time to definitive care. The group also felt it would be important to disseminate information on preventable mortality, probability of survival, and trauma related morbidity. The group felt it was important to promote ideal care for the injured with effective communication using multiple media outlets. Finally, the group felt it was important to increase financial support for trauma care with training in advocacy, grant writing, and developing public-private partnerships.

Session 4: Setting an agenda for action and developing a global network for advocacy.

Objectives: Develop an agenda for action on which Forum participants will agree to work together over the next ten years. This will include initiatives to get greater attention to trauma care globally and concrete actions to achieve the above goals and priorities.
Objectives: Decide the form in which such a global network for trauma care advocacy could be created, who its members should be, and how it should communicate and function.

Group 1: Participants emphasized the need to be guided by the WHA resolution 60.22, having made the assumption that emergency care for trauma patients is part of the mandate. They also highlighted

the requirement for an agreed name for the initiative, suggesting a 'Global Alliance' approach. Suggestions included the following: the development of the data systems to assess trauma care including pre-hospital care, setting standards for quality trauma care systems and have systems for scaling them, providing advocacy, policy directions and guidance to reach essential trauma care to all the injured, the development of tools for monitoring and evaluation of trauma systems and the development of evidence base for effective interventions and success stories.

Group 2: Participants discussed the time lines involved with the proposed agenda details.
The following components should be addressed in sequence: 1- Setting up and working for an alliance, 2- Initiating collaborative activities, 3- Introducing trauma programmes, 4- Acquiring political support. An alliance might include a loose collaboration with endorsements from all global federations and societies. A collaboration would invite interest from other stakeholders and look for funding partners; this would include the setting up of a secretariat, task force and promoting an symbolic logo. To ensure success, the group suggested aiming for follow up analysis in 2 years. Collaborative activities would include data collection on specific indicators, a sustainable solution package. The group suggested developing a short video clip presentation to create interest. To introduce trauma programmes the group felt web based tools, a newsletter and a dedicated website for the alliance would be helpful. Set a fund raising agenda and search for ambassadors / champions. In addition to promoting World Trauma Day. Finally the group felt that to acquire political support we should use the WHA Assembly Resolution as the basis and approach ministries with meeting report and a consensus statement. We should then get endorsement from clinical partners, use regional political forums to promote the alliance and aim for a UN General Assembly Resolution.

Group 3: The participants discussed this topic by identifying the components required to back up the key messages they put forward in session 3:

"Injuries are one of the leading causes of death, and take more than 5 million lives every year"- Quality of available data affects the strength of this statement so the need for improving data collection is paramount.

"Two million of those five million lives can be saved by improving trauma and emergency care"- Recommended by WHO, the introduction of a trauma registry would in part address this statement. Setting up of an electronic global index would also help.

"Low-cost, high impact, sustainable interventions in trauma and emergency care are available"- For this there should be a universal free number which can be used for dispatching transportation, counseling, triage and referral coordination. There should be the establishment of a coordinated public network. We should educate the general population in effective emergency behavior. We should improve standards by re-iterating the importance of clinical algorithms, define essential trauma care, and introduce the essential resources list. Skills and competency building for medical\para-medical community – basic initial critical care (essential curriculum for medical & non-medical).

Group 4: The participants referred to the network as an 'alliance'. They suggested formalization of the relationship, confirming the name of the alliance, the member states, the structure and activities and proposing regular meetings every 1-2 years with web based meetings in between. They also recommended a focal point or representative for the alliance coordinating the national offices/ networks. The members would consist of individuals, professional associations, academic groups, foundations, industries and possibly ministries of health. The alliance would be made up of task forces including pre-hospital systems, hospitals, trauma registries, health economics, research, communication/ media relations, funding and government relations.
With regards to its function, goals, priorities and its mission statement need to be defined. Activities would include connecting members with common interests, promoting exchanges and fellowships, encouraging research and data publication and exchanging ideas. Communication would be maximized with the development and maintenance of a website. As well as providing technical

support to one another, the alliance would also be responsible for inviting other stake holders and act as a platform to relate with governmental agencies.

Group 5: The participants see the alliance as 'a small group of passionate individuals coming together to form loose association, clear goals and programs, and find a big funder (expandable hierarchy)'. It's activities would include the promotion of the care of the injured globally and nationally increasing awareness, education, fund-raising, influencing legislation and policy and targeting decision-makers and funders at all levels. Members of the alliance would include: World Health Organization and other UN bodies, professional organizations of caregivers (global and national), victim and patient organizations, global alliances (violence prevention, road safety, safe cities), potential donors, industry, political organizations, supra-national organizations (political e.g. European Union, Africa Union, the motor industry, celebrities and insurers). The forum would require a constitution, a full-time secretariat, a web-site, newsletter and organizational e-mail links, focus groups (conflict and post-conflict, road traffic crashes, burns, penetrating injury, violence against women, children aged etc), and annual meetings to enable reporting and planning.

Appendix D.

SIXTIETH WORLD HEALTH ASSEMBLY **WHA60.22**

Agenda item 12.14 **23 May 2007**

Health systems: emergency-care systems

The Sixtieth World Health Assembly,

Having considered the report on health systems: emergency-care systems;[1]

Recalling resolutions WHA56.24 on implementing the recommendations of the *World report on violence and health* and WHA57.10 on road safety and health, which respectively noted that violence was a leading worldwide public health problem and that road-traffic injuries caused extensive and serious public-health problems;

Further recalling that resolution WHA56.24 requested the Director-General to provide technical support for strengthening trauma and care services to survivors or victims of violence, and that resolution WHA57.10 recommended Member States to strengthen emergency and rehabilitation services, and requested the Director-General to provide technical support for strengthening systems of prehospital and trauma care for victims of road-traffic injuries;

Recognizing that each year worldwide more than 100 million people sustain injuries, that more than five million people die from violence and injury, and that 90% of the global burden of violence and injury mortality occurs in low- and middle-income countries;

Aware of the need for primary prevention as one of the most important ways to reduce the burden of injuries;

Recognizing that improved organization and planning for provision of trauma and emergency care is an essential part of integrated health-care delivery, plays an important role in preparedness for, and response to, mass-casualty incidents, and can lower mortality, reduce disability and prevent other adverse health outcomes arising from the burden of everyday injuries;

Considering that WHO's published guidance and electronic tools offer a means to improve the organization and planning of trauma and emergency care that is particularly adapted to meeting the needs of low- and middle-income countries,

1. CONSIDERS that additional efforts should be made globally to strengthen provision of trauma and emergency care so as to ensure timely and effective delivery to those who need it in the context of the overall health-care system, and related health and health-promotion initiatives;

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[1] Document A60/21.

2. URGES Member States:

(1) to assess comprehensively the prehospital and emergency-care context including, where necessary, identifying unmet needs;

(2) to ensure involvement of ministries of health in, and an intersectoral coordination mechanism for, review and strengthening of the provision of trauma and emergency care;

(3) to consider establishing formal and integrated trauma and emergency-care systems and to draw on informal systems and community resources in order to establish prehospital-care capacity in areas where formal, prehospital, emergency medical-care systems are impractical;

(4) in settings with a formal, emergency medical-care system, and where appropriate and feasible, to ensure that a monitoring mechanism exists to provide improved pertinent information and assure minimum standards for training, equipment, infrastructure and communication;

(5) in locations with a formal, emergency medical-care system, or where one is being developed, to establish, and make widely known, a universal-access telephone number;

(6) to identify a core set of trauma and emergency-care services, and to develop methods for assuring and documenting that such services are provided appropriately to all who need them;

(7) to consider creating incentives for training and to improve working conditions for health-care providers concerned;

(8) to ensure that appropriate core competencies are part of relevant health curricula and to promote continuing education for providers of trauma and emergency care;

(9) to ensure that data sources are sufficient to monitor objectively the outcome of efforts to strengthen trauma and emergency-care systems;

(10) to review and update relevant legislation, including where necessary financial mechanisms and management aspects, so as to ensure that a core set of trauma and emergency-care services are accessible to all people who need them;

3. REQUESTS the Director-General:

(1) to devise standardized tools and techniques for assessing need for prehospital and facility-based capacity in trauma and emergency care;

(2) to develop techniques for reviewing policy and legislation related to provision of emergency care, and to compile examples of such legislation and to use such institutional capacity to provide support to Member States, on request, for reviewing and updating their policies and legislation;

(3) to determine standards, mechanisms, and techniques for inspection of facilities, and to provide support to Member States for design of quality-improvement programmes and other methods needed for competent and timely provision of essential trauma and emergency care;

(4) to provide guidance for the creation and strengthening of mass-casualty management systems;

(5) to provide support to Member States, upon request, for needs assessments, facility inspection, quality-improvement programmes, review of legislation, and other aspects of strengthening provision of trauma and emergency care;

(6) to encourage research and collaborate with Member States in establishing science-based policies and programmes for implementation of methods to strengthen trauma and emergency care;

(7) to collaborate with Member States, nongovernmental organizations and other stakeholders in order to help ensure that the necessary capacity is in place effectively to plan, organize, administer, finance and monitor provision of trauma and emergency care;

(8) to raise awareness that low-cost ways exist to reduce mortality through improved organization and planning of provision of trauma and emergency care, and to organize regular expert meetings to further technical exchange and build capacity in this area;

(9) to work with Member States to design strategies for providing, on a regular basis, optimal, non-emergency and emergency care to all those in need; and to provide support to Member States for mobilizing adequate resources from donors and development partners to achieve this goal;

(10) to report on progress made in implementing this resolution to the Health Assembly, through the Executive Board.

Eleventh plenary meeting, 23 May 2007
A60/VR/11

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