►What You Should Know

National Statistics

According to the Centers for Disease Control, 18 people in the U.S. die every hour due to injuries.[1] Unintentional injuries are the fifth leading cause of death in the U.S. and responsible for sending one of every three people to the emergency room for treatment.[1] In 2000 alone, injuries resulted in more than 148,000 deaths.[2] Nearly 30 million people were treated in U.S. emergency rooms for nonfatal injuries in 2001, and 1.6 million of those were later hospitalized or transferred for specialized care as a result of their injury.[1] Injury-related medical expenditures costs reached an estimated $117 billion in 2000, approximately 10% of total U.S. medical expenditures.[3]

For combined age groups, motor-vehicle crashes were the leading cause of fatal injuries and unintentional falls were the leading cause of nonfatal injuries treated in emergency rooms in 2001.[1] Distinguishing injuries by age group, the young and old appear to be affected disproportionately. Among adults over 65, fall-related injuries account for 62% of unintentional injuries treated in emergency rooms, and the death rate from falls is five times higher among adults over 75 than in any other age group. For young children aged 1-4 years, drowning is the leading cause of injury death, accounting for one in four injury-related deaths.[1] Further, when young lives are lost, it is important to consider the impact on society through what these people would have contributed.

Injuries are classified as unintentional or intentional (suicide, homicide, etc.). Although the events leading to intentional and unintentional injuries may differ widely, the mechanisms of injury and the injuries themselves are usually similar.

Oklahoma Statistics

In Oklahoma, injuries are the third leading cause of death (behind heart disease and cancer), accounting for more than 2,000 deaths each year. Injuries are the leading cause of death and lifelong disability among persons 1-44 years of age. After the first year of life, more children die

from injuries than all other causes of death combined. Almost two-thirds of injury deaths are unintentional (64%). The leading causes of injury death are traffic crashes, suicide, homicides, falls, fire/burns, and drugs/poison. Among teens, the leading causes of all deaths are traffic crashes, suicide, homicide, and drownings. From 1992 - 2000, Oklahoma's death rates due to traffic injuries, drownings, fire/burns, falls, homicide and suicide were higher than national rates.

Males are more than two and one half times as likely to die from injuries than females. Persons 15-24 and 65 years of age and older are at highest risk of dying from an injury. African Americans have the highest injury death rate among all age groups except those 65 years and older. Overall, African American males 15-24 years of age have the highest risk of injury death. Injury death rates are more than 20% higher for non-metropolitan regions of the state than metropolitan regions. More than one-third of persons who die from an injury in Oklahoma have a positive blood alcohol concentration (BAC).

►What Works

Many people think injuries are unavoidable, chance happenings. In reality, injuries, like diseases, occur in highly predictable patterns. Utilizing a public health approach, injuries can be prevented. This approach requires program planners to determine the scope of the problem through data collection, identify risk and protective factors, design and evaluate interventions based on that information, and implement programs and provide information to the public.

While the circumstances leading to an injury, such as a motor vehicle crash, may not be avoidable, the injuries sustained in that crash can often be prevented or lessened by wearing seat belts or having airbags in the vehicle. Wearing bicycle or motorcycle helmets, installing smoke alarms in residences, and constructing four-sided fences around swimming pools are examples of other proven effective injury prevention strategies.

Public Health Approach To Injury Prevention

- **Define the problem**
- **Identify risk and protective factors**
- **Develop and test prevention strategies**
- **Assure widespread adoption**

Community-based public health providers are essential in the fight against unnecessary death and disability caused by injury. Because each community is different, with unique weaknesses and strengths, programs and projects should be developed that best fit the community's needs. Injury prevention should be strongly rooted in community involvement and input. Programs that use a variety of approaches are most likely to be successful. Public education, product distribution (bicycle helmets, smoke alarms, child safety seats, etc.), comprehensive legislation, effective enforcement, and modified environments are a few examples of a multifaceted approach to a successful injury prevention program. Begin the prevention efforts with a success and build on that success.

►What You Can Do *Reprinted from "Lifesavers II: A Guide to Smoke Alarm Projects*

***Find out who, what, where, when, and why*.**

Begin by gathering local information and statistics about injuries and deaths. Demographic and statistical information is available from a variety of sources including the U.S. Census Bureau, Oklahoma Department of Commerce, Oklahoma State Department of Health, local county health departments, Indian Health Service, as well as Appendix A and the Where You Can Go sections of this manual. Such information can be used to identify census tracts where the percentage of the high-risk populations (such as those less than five or more than 65 years of age) is higher. The Injury Prevention Service can provide data on hospitalized and fatal injuries. The information should be used to concentrate resources in areas with the greatest need, and to plan and evaluate the project.

Recruit the right people to build a coalition.

A coalition is a group of people and organizations that unite to collaboratively address and impact a specific problem. Coalitions lend themselves to resource and information sharing; greater community credibility; sharing of experiences, perspectives, and theories; and broader objectives (beyond the limited objectives of a single organization). Coalition members should represent a wide and diverse cross-section of the community, including members of the audience you plan to reach, representatives from organizations which already serve the intended audience, and people with personal interest in the prevention effort.

Interested and resourceful persons from groups such as media, schools, civic clubs, hospitals, intended population leaders, public safety, health department, and volunteer groups can make a "good" project a GREAT project. Coalition members need to bring with them different perspectives, enthusiasm, and resources like time, people, money, effort, ideas, and commitment.

***Make a road map*.**

Have a plan for where the project is, where it is going, how you are going to get there, and how to measure your progress. Devise a set of preliminary goals and objectives. What are you trying to accomplish (e.g., the prevention of residential fire-related injuries, increase the number of children in car seats)? Who is your intended audience (e.g., a certain neighborhood, older adults, young children)? Identify what others have done and find out what made it successful or what made it unsuccessful. Be able to determine if the project is reaching those who are in need. Be ready to modify the plan if it is ineffective.

Know the audience.

Statistics and demographics can tell a lot about a high-risk population, but data cannot tell the whole story. Different audiences receive a safety message differently. Focus group interviews and involving representatives from the intended population in the planning process can help identify cultural factors (cooking habits), attitudes (mistrust of the system), and environmental conditions (burglar bars on all exits) that could affect the effectiveness of the project. Present relevant and practical prevention messages and experiences to the intended audience. For example, if home burglary is perceived as a greater risk than residential fire, a project to remove unsafe burglar bars from windows will not be successful without first addressing the crime issues in the area.

***The hard-to-reach are hard to reach*.**

A variety of methods are needed to reach different sections of the community and bring about change. Utilize different ways of providing information, education, and products. The use of radio, television, newspapers, public speaking engagements, schools, and civic groups are all useful, but other ways to reach the hardest to reach are needed. Tap into groups who are already reaching that audience. Examples of some

established programs which already reach and serve the high-risk groups are: community action agencies, meals-on-wheels, immunization clinics, flu clinics, WIC programs, senior nutritional centers, neighborhood associations, ethnic churches, and the Department of Human Services. Go to the audience—do not wait for them to come to you.

Never buy what you can get for free.

It is important to have a clear understanding of the needs of your injury prevention project, as well as the resources available within the community to supply those needs. Both financial and human resources will be crucial in determining your success. Use volunteers from organizations such as the Girl and Boy Scouts, 4-H clubs, honor societies, service clubs, utilities, churches, or businesses. Individuals, businesses, or organizations can donate materials such as reams of paper, copying services, money, or other in-kind donations. Trained volunteers from the intended audience can also be effective peer educators.

***Let the community know about the great things you are doing*.**

Display posters or flyers with information about how to obtain injury prevention services in grocery stores, laundromats, schools, child care centers, health clinics, fast food restaurants, banks, convenience stores, etc. Advertise the project, reach new audiences, and reinforce messages and behaviors through the use of multiple outlets. Use outlets such as billboards, newspaper articles, radio messages, local public service announcements, church bulletins, or display booths. The more ways a message is presented, the more effective it will be. Tell anyone and everyone about what is being done to make your community a safer place to live.

***Be flexible - change to meet the needs*.**

When planning your project, keep in mind competing community events. Either delay your plans or move your project to join the other event. Plan for when the audience will be there. For example, if distributing smoke alarms door-to-door, go on the weekend or in the early evening when more people are at home. It is important to gauge the responsiveness to the planned project. If the audience is not responding, be flexible and change the plan to reach those in need. Sometimes immediate priorities change, but be faithful to come back to the plan.

Give the responsibility for prevention to the community and audience.

Injuries are not accidents; most can be predicted and therefore prevented. The individuals and the community own the conditions that lead to the injury problem. Therefore, the individuals and community have the responsibility for prevention. Respect the audience and plan projects that transfer responsibility for prevention to them. Provide the community and individuals with the awareness of the injury problem and information on how to prevent injuries. For example, the project personnel can install a smoke alarm in a home, but the occupant has to take the responsibility of keeping the alarm installed and functioning (i.e., leaving the battery in and changing the battery when needed) and practicing safety behaviors. Prevention is everybody's business.

References

1. Centers for Disease Control and Prevention. Surveillance for Fatal and Nonfatal Injuries, United States, 2001. *MMWR.* 2004;53 (SS-7):1-58.

2. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. *Web-based Injury Statistics Query and Reporting System (WISQARS)*. August 2004. Available from: http://www.cdc.gov/ncipc/wisqars. Accessed October 16, 2002.

3. Centers for Disease Control and Prevention. Medical Expenditures Attributable to Injuries, United States, 2000. *MMWR.* 2004;53(1):1-4.