commitment to play an active role in improving legislation in public health or road safety in their country. The level of engagement of the Legal Development Programme members in regulatory mechanisms on the topic in country has also been enhanced.
Conclusions During 2012–2014 participants who regularly took part in face-to-face workshops showed longer-term and active involvement in improving road safety regulation in their country. Countries supported also showed better improvement in evidence-based regulation (either in the number of changes or in the extent to which the changes are in line with evidence). Although the impact of the Legal Development Programme has not yet been assessed, it has so far generated greater interest than the previous capacity development programme (through an increase in number of participating members since the launch) as well as more active involvement in various aspects of the road safety regulatory process.

30 CAPACITY DEVELOPMENT FOR INJURY PREVENTION & CONTROL IN LOW- AND MIDDLE-INCOME COUNTRIES: HARNESSING THE POTENTIAL OF MOBILE TECHNOLOGIES

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10.1136/injuryprev-2016-042156.30

Background Internet and mobile connectivity have increased exponentially around the globe over the last decade. Consequently, technological advances have made a diverse range of options available for multimedia consumption, and led to the development of a variety of platforms for distance education. While other disciplines have taken advantage of these platforms to expand the reach of training and capacity development programs, this has not been the case for the field of injury prevention and control.
Methods We established the first free online and on-demand program on Road Traffic Injury Prevention and Control in Low- and Middle-Income Countries (RTIP). The program is comprised of six educational modules spanning the very basics of RTI prevention, key concepts, risk factors for RTIs, injury surveillance systems, evaluation design for RTI prevention programs and how to influence public policy. Although specifically designed with a foundation in public health approaches to the problem of RTIs, the program is applicable to many contexts – especially for persons without formal training in research methods as is the case in many LMICs. The program is self-paced – participants must complete pre- and post-evaluations to advance between the modules in the program's sequence.
Results RTIP was launched in April 2013, and since then has had 1,542 enrolments from 132 countries. Among those who advance from the first module, 43% go on to complete the program. 63% are male, with the majority of participants being between the ages of 20–49 years. Most of the participants have either a Bachelors or Masters degree (69%), and 73% are either working professionals, students, or government officials. Only 16% of the participants identified themselves as researchers. A wide range of disciplines are represented by the participants with the top 5 being Public Health (23%), Engineering (14%), Transportation (9%), Social Sciences (8%), and other health sciences (7%).
Conclusions As seen from the RTIP program online platforms present a remarkable opportunity for the field of injury prevention to expand the reach of capacity development programs—to persons in resource poor settings who may not have access to formal training programs, or those who may be interested in continuing education.

Pre-Conference Sessions Sunday 18.9.2016 10:00–12:00

SU AP W 1

31 DEVELOPING AND EVALUATING TRAUMA CARE SYSTEMS IN LOW- AND MIDDLE-INCOME COUNTRIES (LMICS): EXPERIENCES IN AFRICA

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Background Injuries kill more than 5 million people around the world each year. More than 90% of these deaths occur in low- and middle-income countries (LMICs), and road traffic injury (RTI) is the most common mechanism of fatal injury, with an estimated 1.24 million deaths per yea. RTI fatality rates are two to three times higher in LMICs than in high-income countries (HICs), due to a variety of factors including differences in road construction, vehicle conditions, and the existence and enforcement of laws regulating safety behaviours. An additional factor is the lack or poor quality of trauma care systems in many LMICs. As a consequence, fatality rates for the moderately and severely injured are more than 50% higher in LMIC than in the United States, and an estimated 1.73 million lives could be saved each year if trauma care capabilities could be brought to par with those of HICs.
Moderator Dr. Adnan A. Hyder, Johns Hopkins International Injury Research Unit (JH-IIRU, USA)

- **Welcome and overview of trauma in low- and middle-income countries –** *Dr. Adnan A. Hyder,* Johns Hopkins International Injury Research Unit, USA
- **Talk 1: Efforts to improve the care of the injured in Kenya – successes and struggles –** *Dr. Isaac Botchey,* Johns Hopkins International Injury Research Unit, USA
  - Abstract: Kenya is a LMIC in East Africa with a population of 40 million people. Injury is the second leading cause of death after HIV/AIDS in Kenya and the number of people injured is on the rise. There is a lack of coordinated, integrated pre-hospital, hospital and rehabilitative care in Kenya. The Bloomberg Philanthropies Global Road Safety Program (BPGRSP) was a five-year, ten-country effort to reduce the mortality associated with RTIs. The goal of the Johns Hopkins International Injury Research Unit's (IIRU) trauma care activities in Kenya was to improve the care of the injured through a systematic, multi-faceted, evidence-based approach. A literature review and a trauma system profile was performed based on which a nine point plan was set to achieve our objective. The nine-point plan was centred on stakeholder engagement, trauma registry development and implementation; pre-hospital and hospital care training as well as strengthening of trauma-care legislation.

- **Talk 2: Role of trauma registries to improve quality of care in developing countries – case studies from three different settings –** *Dr. Amber Mehmood,* Johns Hopkins International Injury Research Unit, USA
  - Abstract: Trauma registries play an important role in performance improvement and hospital-based injury surveillance. Case studies from Pakistan, Kenya and Kampala are presented with details about inclusion, exclusion criteria, data collection platform, implementation model, funding sources and stakeholder engagement. All three registries used electronic platforms, however implementation strategies differed. Dedicated trauma registry personnel results in reliable capture of cases, complete follow up of patients and better quality of data but has higher cost of operation. Trauma registries not only helped in measuring hospital injury burden but also helped documenting the care processes with potentially impactful solutions. Implementation of trauma registries may cause both direct and indirect positive impact on trauma care in the hospital regardless of method of implementation. Long term and sustainable impact could only be seen with strong support from key hospital administrators.
- **Talk 3: Developing an internet-based traumatic brain injury registry in Uganda –** *Dr. Olive Kobusingye,* Makerere University School of Public Health, Uganda
  - Abstract: The primary aim of this review was to define core variables for an internet-based data registry focused on TBI in Uganda. A comprehensive review was conducted. Six databases including PubMed/Medline, Embase, Scopus, Cochrane Reviews, System for Information on Grey Literature and Global Health Ovid were searched for literature pertaining to TBI in the African region and TBI registries in low-and middle-income countries. Thirty-five articles were identified as relevant to the focus of inquiry. The majority of the articles were from Nigeria, followed by South Africa and Tunisia. Few included definition used to define TBI. The most commonly collected core variables were demographics, injury event, initial assessment, emergency department care, in-patient care and outcome at hospital discharge.
- **Discussant: Steps forward: what are the best "systems" to care for the injured in low-resource settings** – Dr. Junaid Razzak, Johns Hopkins International Injury Research Unit, USA
- **Q&A** – Dr. Adnan A. Hyder, Johns Hopkins International Injury Research Unit, USA

Intimate Partner Violence

SU AP W2

32 BETTER SERVICES FOR VICTIMS OF DOMESTIC VIOLENCE. CLOSE COOPERATION BETWEEN THE PUBLIC SECTOR, NGOS AND EXPERTS BY EXPERIENCE

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Background In Finland we have for many years worked to improve the public services (health care and social services) for victims of domestic violence. The specialised services for victims of domestic violence are usually run by NGOs. One of the obstacles has been that the staff in social- and health care don't identify the victims of domestic violence. There is still lack of education but the main reason is that they don't ask about violence. Domestic violence enquiry and assessment form has been develop and used in different settings but there is still need to spread the use of the form. The aim of the project (VÄISTÖ) we are presenting includes not only the use of routine enquiry but also how to intervene in domestic violence and establish the practice and develop public services.

Methods The VÄISTÖ-project is part of the National Development Plan for Social Welfare and Health Care (Kaste Program). The purpose is that national, regional and local actors work together to create and implement good practices. This project is implemented in the municipalities of North Karelia and South Savo areas together with two NGOs Viola Free From Violence (SAUMURI-project) and Victim Support (ORAVA-Project). The roles of NGOs have been important when it comes to engaging the Experts by Experience in the development work.

The service developments that have been done are following:

1. Define the roles of domestic violence work in social- and health care public services. How is doing what and when.
2. Dictate the responsibilities and put it in the structures. For example it is your obligation to intervene in domestic violence.
3. Dictate the coordination between different agencies.
4. The service developments have only been achieved by close teamwork between professionals, experts and Experts by Experience.

Results and Conclusions The key learning from this project has been that use of routine enquiry helps professionals in social- and health care settings better intervene in domestic violence. The professionals need an ongoing education in using the enquiry and assessment form. Despite education the professionals also need some expert to consult in situations when domestic violence is disclosed. In public services we also need professionals who are experts in domestic violence issues. One of the key findings in this service model is that the clients are getting more coordinated and comprehensive help. The clients are not as often as earlier redirected from one place to another.

33 HEARING THE VOICE OF DISABLED PEOPLE. DEVELOPING BETTER SERVICES OF DOMESTIC VIOLENCE

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10.1136/injuryprev-2016-042156.33

Background The New Social Welfare Act in Finland highlights citizens' equal access to the services, as well as municipalities' responsibility to collect users' experiences from service system and organise specialised services for victims of domestic violence.

Description of the problem As a marginal group, particularly people with disability are very vulnerable. They position is weak in the service system in getting help as a victim of domestic violence. Also, domestic violence is an untold problem in their own