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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10.1136/injuryprev-2016-042156.31

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.