

# What is in the name? What is our game?

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In 2019, a presentation for a variety of stakeholders was arranged as part of the launch event for a publication documenting the subnational magnitude of road traffic injuries in India as estimated by the Global Burden of Disease Study.<sup>1</sup> I did not use the term ‘road accident’ and explained to the audience the need to move away from that term because accidents do not happen, they are caused. All the questions and comments that followed the presentation used ‘road accident’. The same was explained by me in another meeting to a very different audience—researchers at a leading global vehicle manufacturer. After the presentation, the president of the company said that he hoped that I slipped and used ‘road accident’ at least once during the presentation or interaction, but I did not. He was pleased with my devotion to convey that prevention is possible. And then, he went on to use ‘road accident’ in his speech. In fact, in my 20 years of work as an injury researcher, I have failed to get the vast majority of the stakeholder not to use ‘accident’.

And it is all in the name.

McClure, in his editorial in June 2021,<sup>2</sup> invited the *Injury Prevention* readers to look through that issue from the perspective of a decision-maker to assess if the authors got it right—right enough to make sure people used these results as a basis for their decisions. We did so for the injury research that our team has done over the last two decades which has focused on road traffic injuries and suicides, and with

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some work on drowning, gender violence and snake bites. Irrespective of the injury that one considers, we have found underreporting of deaths in the official statistics of India, which are generated by the police as injuries are reported as *crime* in India.<sup>3</sup> The government stakeholders involved in addressing injuries are varied and disconnected—the police is under the Ministry of Home Affairs, road traffic safety is under the Ministry of Road Transport and Highways, and the Ministry of Health predominately deals with cases post injury. Looking back at our work, has our research resulted in any difference in the underreporting? No. Have we managed to integrate the different stakeholders in our research? No. Did the data generate effect on policy or programme? For the most part, no. The data clearly *do not* speak for themselves.

How does one then address the injury decision-making process to save lives? First, we need to purposively work with the system, which is scattered and possibly disinterested. Change can go only thus far by reporting on injury epidemiology in publications and scientific meetings; we need to be more effective in communicating better with the decision-makers. Second, prevention interventions have to go beyond routine risk factors to encompass social determinants of injuries to make a difference in the long term. Third, we need to move out of our silos of road traffic injury, suicide, burns or drowning researchers to stress on the policymakers as *injury researchers* that injuries can no longer be ignored. It is important that we are heard collectively. Fourth, we learn from each other. For example, lived experience concept<sup>4,5</sup> is promoted in suicide prevention because people—as suicide attempt survivors, who have experienced

a suicidal crisis, and those who have lost a loved one to suicide—can be powerful agents for challenging prejudice, facilitating action and for generating hope for people at risk. We need to foster such engagements for other injuries as well. Finally, funding for injury research is limited and we need to make better decisions on the type of research we spend that money on with the aim of maximising population health gain.

It is time to change our game.

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