

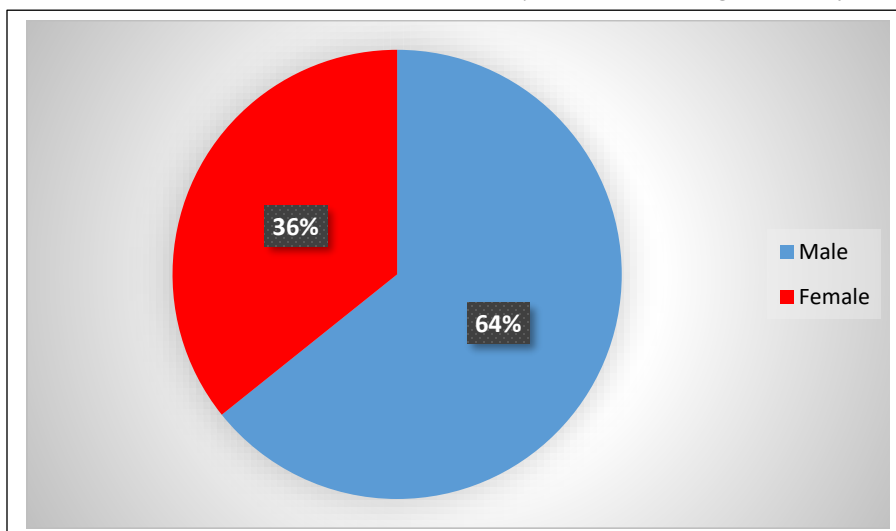
7. Injuries due to intention (Intentional and deliberate self-harm)

- Out of all intentional injuries, more males were affected
- Unlike other injuries, females were mostly affected due to deliberate self-harm
- Individuals of 16 – 40 years of age were affected mostly due to intentional injuries
- Individuals of 16 – 25 years of age were the mostly affected age group due to deliberate self-harm.
- 56% of all intentional injuries were due to stuck/ hit by person
- 3/4th of deliberate self-harm was due to poisoning
- 60% of individuals in 16 – 40 years ages were affected by struck/ hit by person, about 50% of individuals in 16 – 25 years were affected due to intentional poisoning.
- Adolescents and youths were mostly affected due to poisoning related deliberate self-harm
- Home was the leading place for intentional injuries (50%) and deliberate self-harm (~80%)

In 2018, details of 18584 victims following intentional injuries and 1812 victims following deliberate self-harm admitted for inward care to sentinel hospitals have been reported through National Injury Surveillance system.

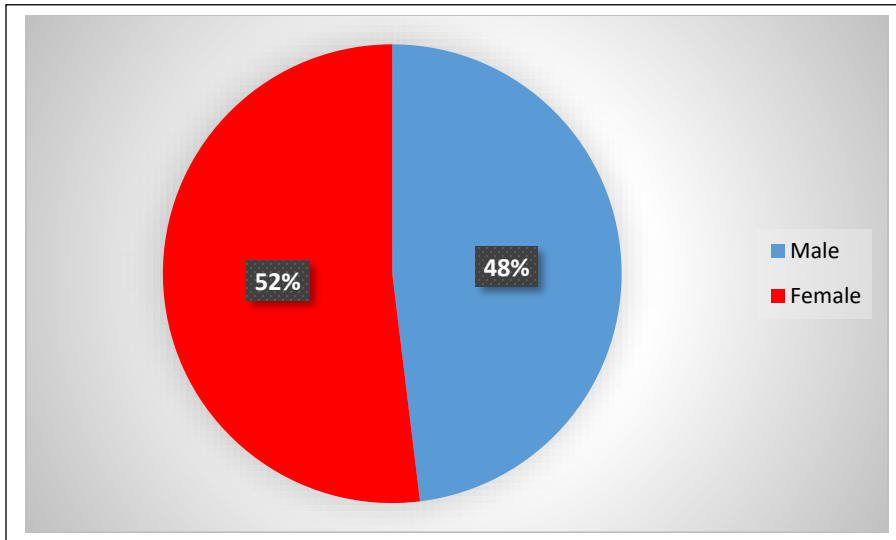
DD. Sex and age distribution of victims due to intentional injuries and deliberate self-harm

Figure 7.1: Distribution of intentional injuries according to sex by percentage



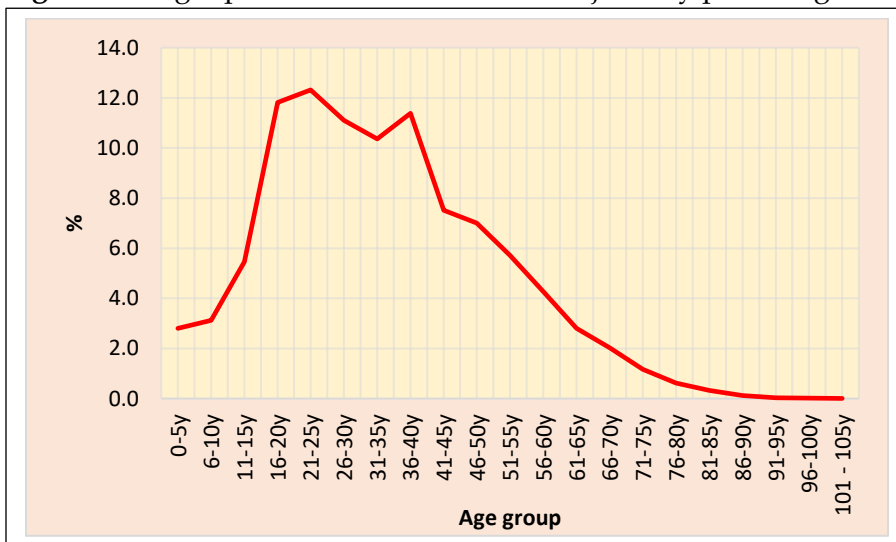
Male to female ratio of the victims was 1.78: 1.

Figure 7.2: Distribution of deliberate self-harm according to sex by percentage



Deliberate self-harm was commonest among females. Male to female ratio of victims of deliberate self-harm was 1: 1.08.

Figure 7.3: Age specific rates of intentional injuries by percentage



Adolescents, youths and young adults from 16 – 40 years of age (47% of the total) were mostly affected

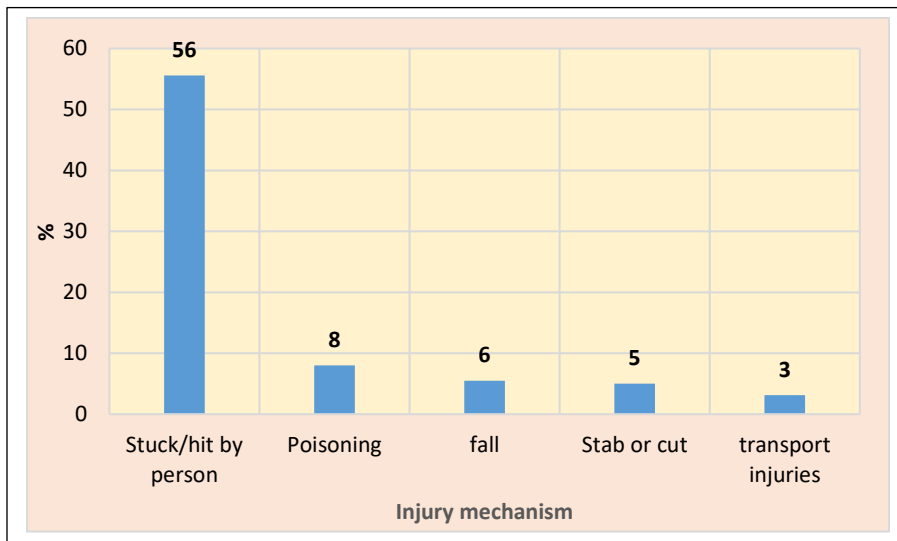
Figure 7.4: Age specific rates of deliberate self-harm by percentage



Adolescents and youths of 16 – 25 years of age were mostly affected (47.4%).

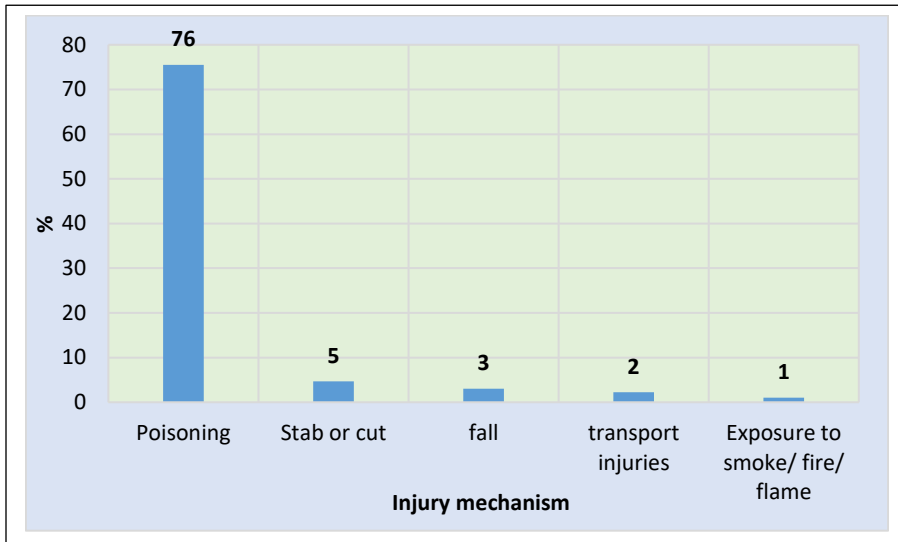
EE. Mechanism of intentional injuries and deliberate self-harm

Figure 7.5: Leading mechanisms of intentional injuries by percentage



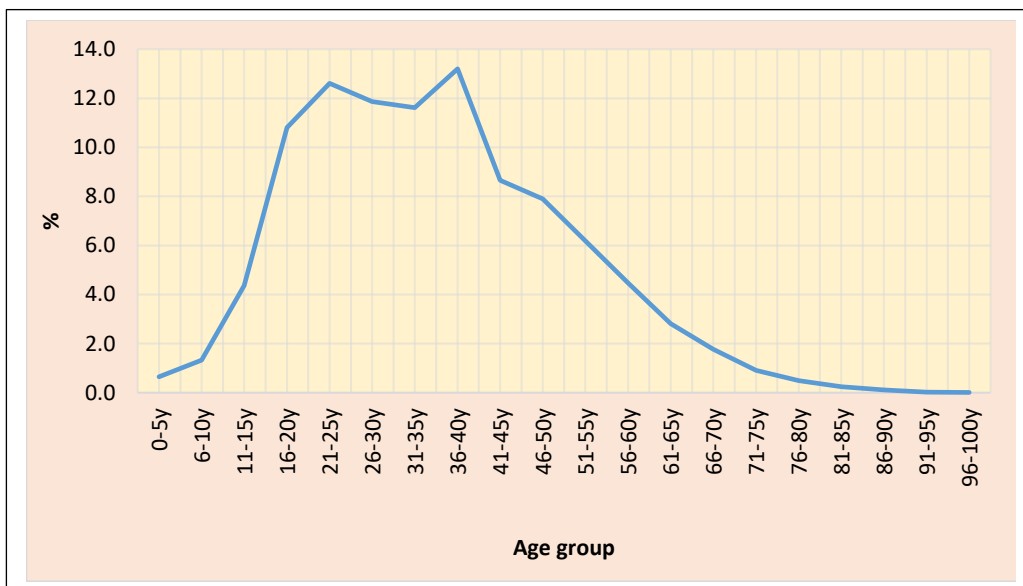
Leading mechanism for intentional injuries was stuck/ hit by person (56%)

Figure 7.6: Leading mechanisms of deliberate self-harm by percentage



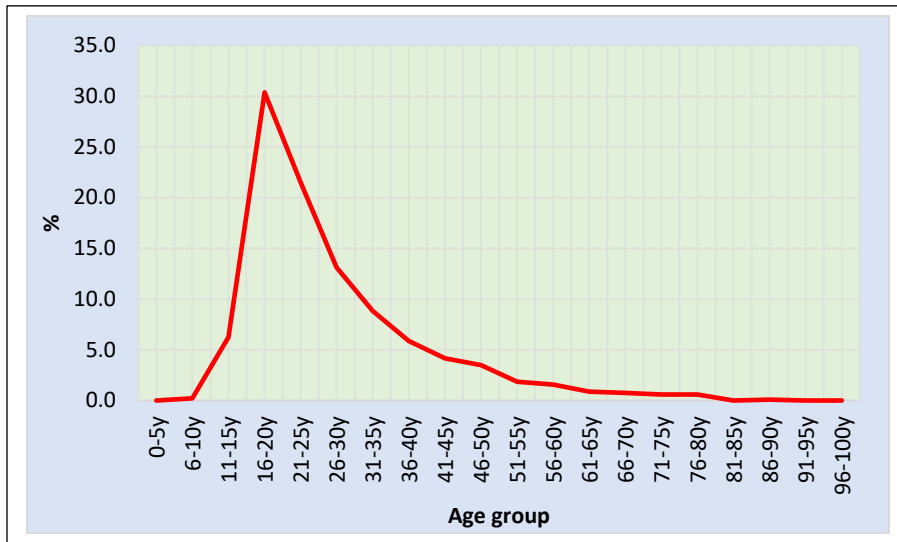
For 3/4 of deliberate self-harm, poisoning was the leading mechanism

Figure 7.7: Age distribution of struck/ hit by person, the leading injury mechanism of intentional injuries



60% of individuals in 16 – 40 years ages were affected by intentional struck/ hit by person.

Figure 7.8: Age distribution of poisoning, leading injury mechanism of deliberate self-harm

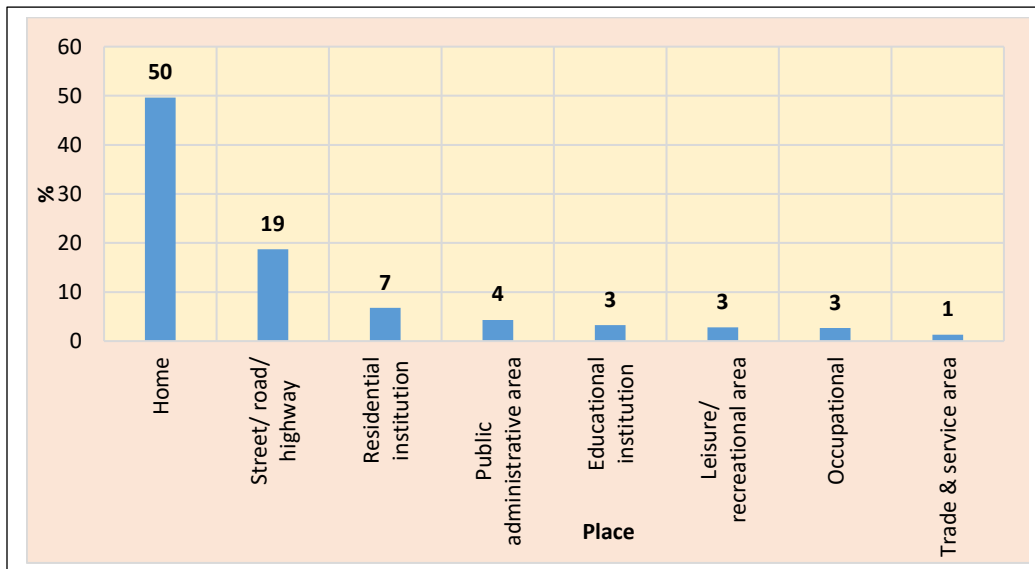


Poisoning was commonest among adolescents and youths from 16 – 25 years of age (52% of all poisoning related deliberate self-harm)

FF. Place of occurrence of intentional injuries and deliberate self-harm

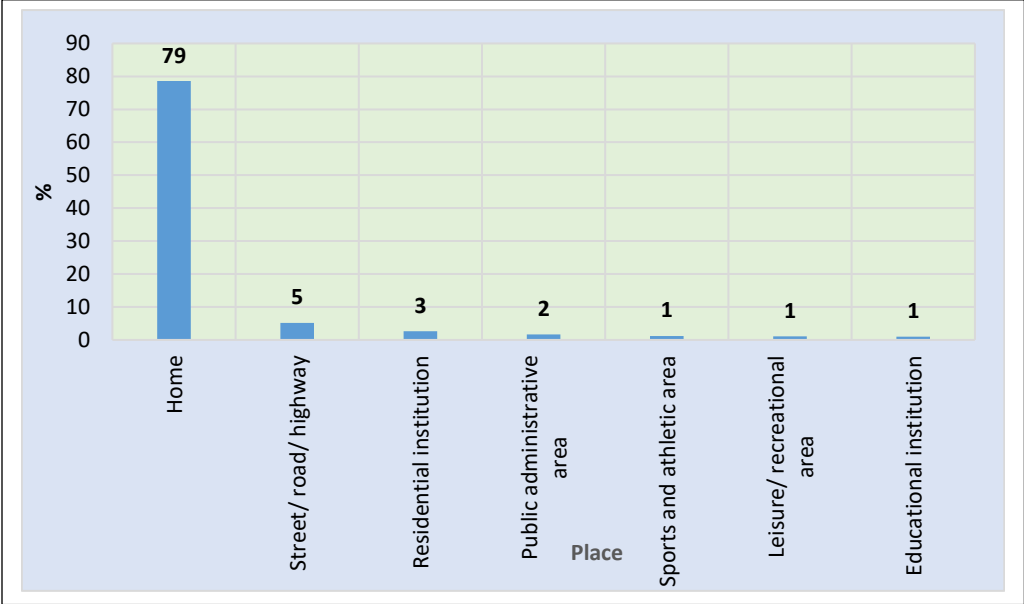
Most of intentional injuries (54%) and deliberate self-harm (78%) occurred at home. 19% and 11% of Intentional injuries and deliberate self-harm respectively also occurred at street/ road/ highways.

Figure 7.9: Common places of occurrence of intentional injuries by percentage



50% of intentional injuries occurred at home followed by street (19%) and residential institution (7%)

Figure 7.10: Place of occurrence of deliberate self-harm by percentage



4/5th of injuries due to deliberate self-harm occurred at home

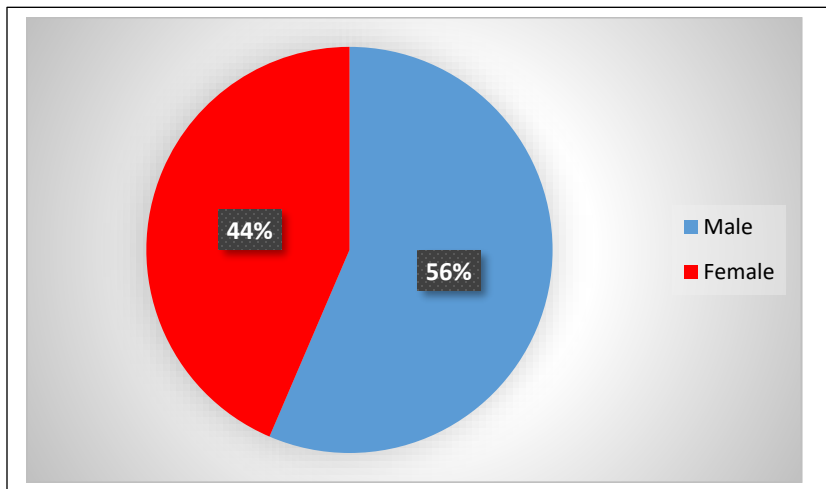
8. Outpatient information of injuries

- 65% of victims were adolescents, youths and young adults.
- Most of the injuries occurred during the day time
- 3/4th of the reported injuries through OPD system was due to animal bites
- Out of all injuries, more males were affected (56%) compared to females (44%). But more females were affected due to animal attack.
- 3/5th of injuries occurred at home
- Most injuries occurred while engaged in leisure activity (31%)
- Superficial injuries occurred in 85% of the victims and lower limbs were affected mostly (55%)
- Evidence of alcohol use and substance use were evident in 1% and 8% of all reported injuries respectively

In 2018, 70314 injury victims treated as outpatients at government hospitals were reported through the national injury surveillance system until the date of analysis.

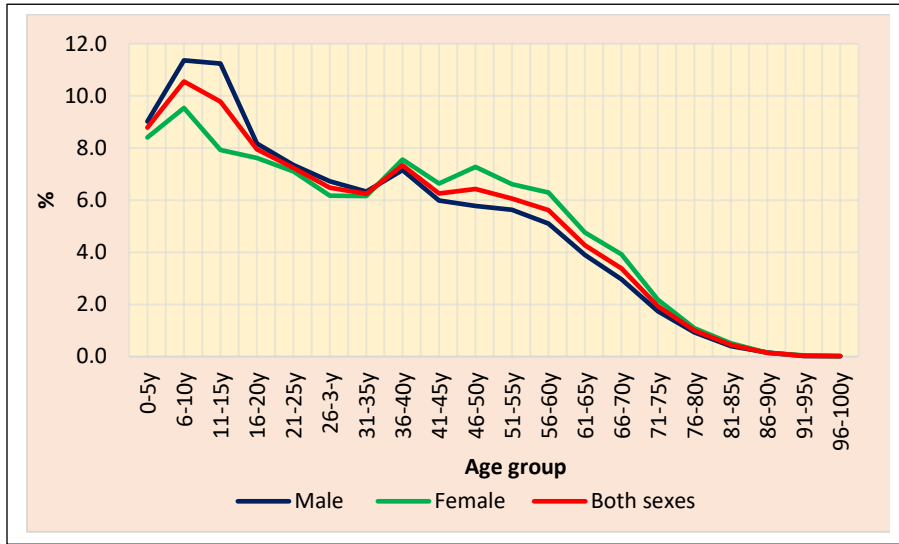
GG. Sex and age distribution of victims

Figure 8.1: Sex distribution of the victims by percentage



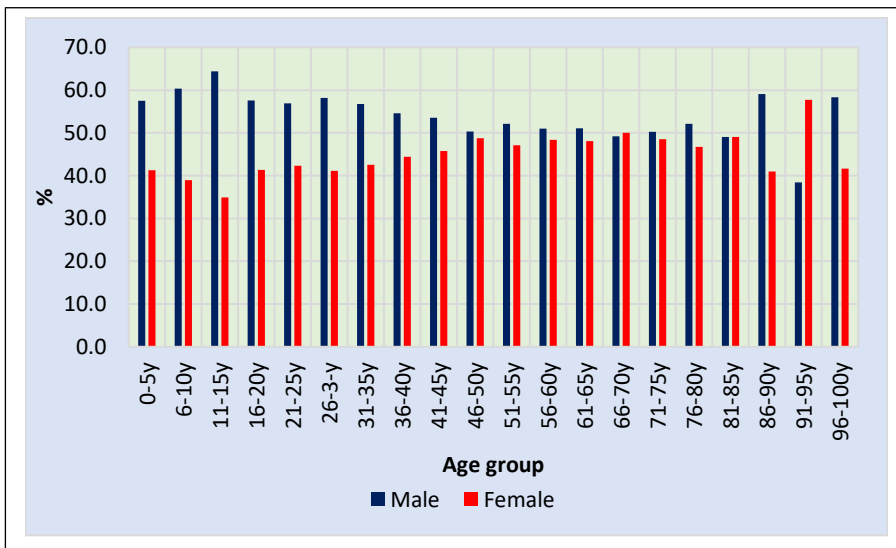
Male to female ratio of the victims was 1.2:1

Figure 8.2: Age distribution of the victims by sex



Children, adolescents, youths and young adults are affected mostly in both sexes (about 65% of all victims).

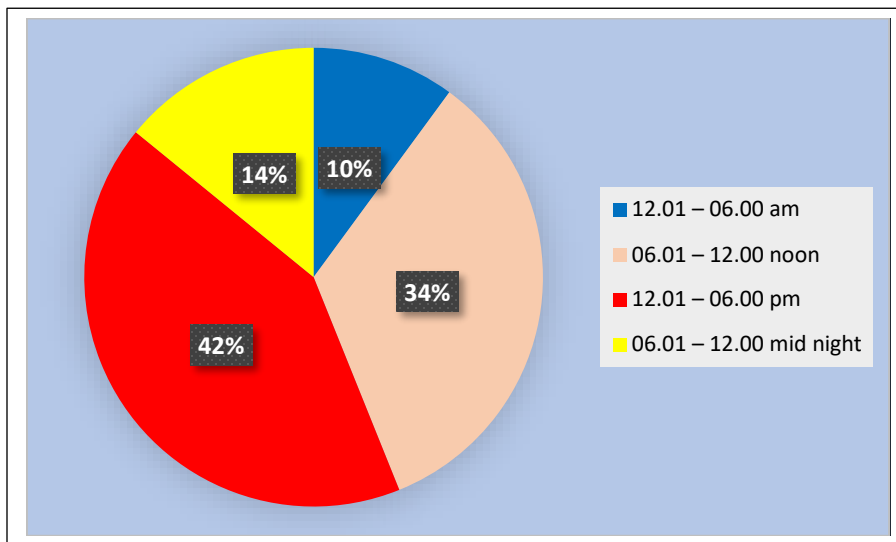
Figure 8.3: Age specific distribution of victims by sex by percentage



Although men were generally more affected, the percentage of affected men among children, adolescents, youths and young adults is significantly higher than women. But this gap is not so prominent in the age groups of over 46 years.

HH. Time of occurrence of injuries

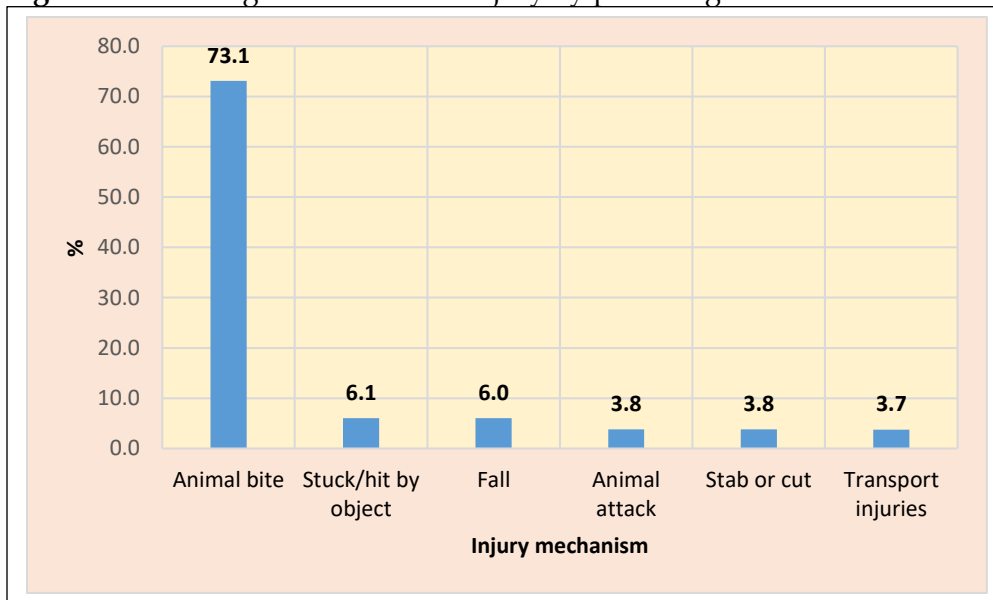
Figure 8.4: Time of occurrence of injuries by percentage



Most of the injuries (3/4th of all injuries) occurred during the day time. But 25% occurred from 6 pm to 6 am.

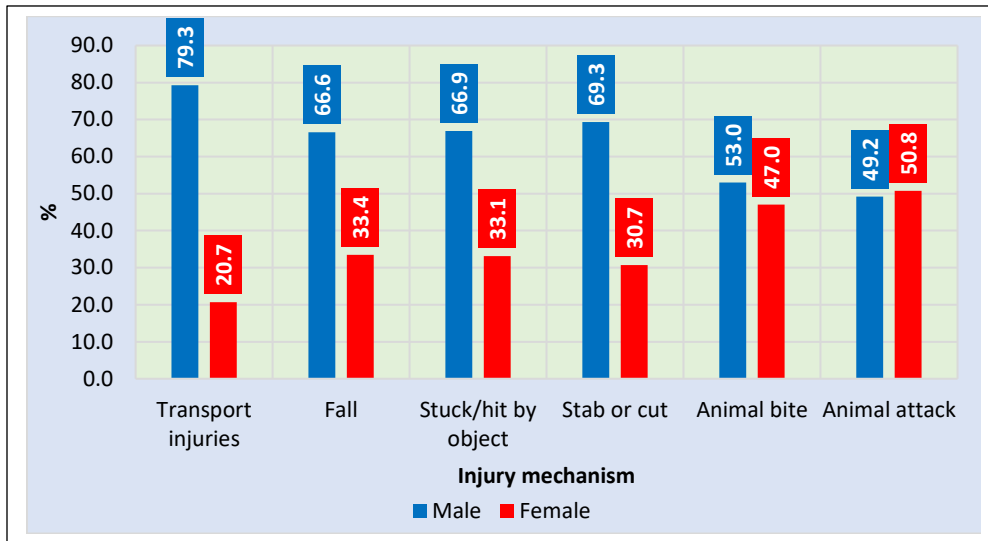
II. Mechanism of injury

Figure 8.5: Leading mechanisms of injury by percentage



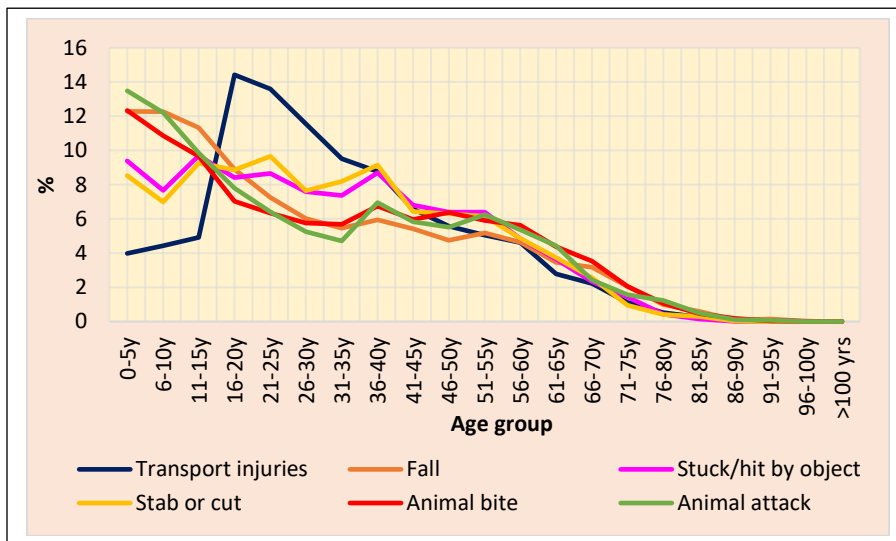
3/4 of all reported injuries were due to animal bites. 96% of reported injuries were due to animal bites, stuck of hit by object, falls, animal attack, stab or cut and transport injuries.

Figure 8.6: Distribution of common injuries by percentage by sex



Males were mostly affected compared to females except in injuries due to animal attacks. Compared to other injuries, more females were affected in animal bites.

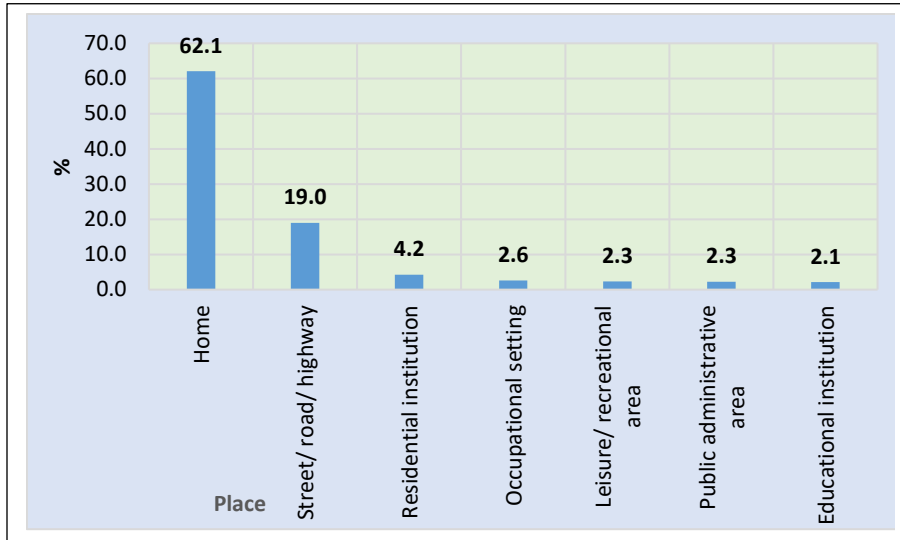
Figure 8.7: Distribution of common injuries by age groups



Except for transport injuries, other injuries were more common among children. Percentages were gradually decreased with increase of age. Transport injuries were more common among 16 – 35-year age group.

JJ. Place of occurrence of injury

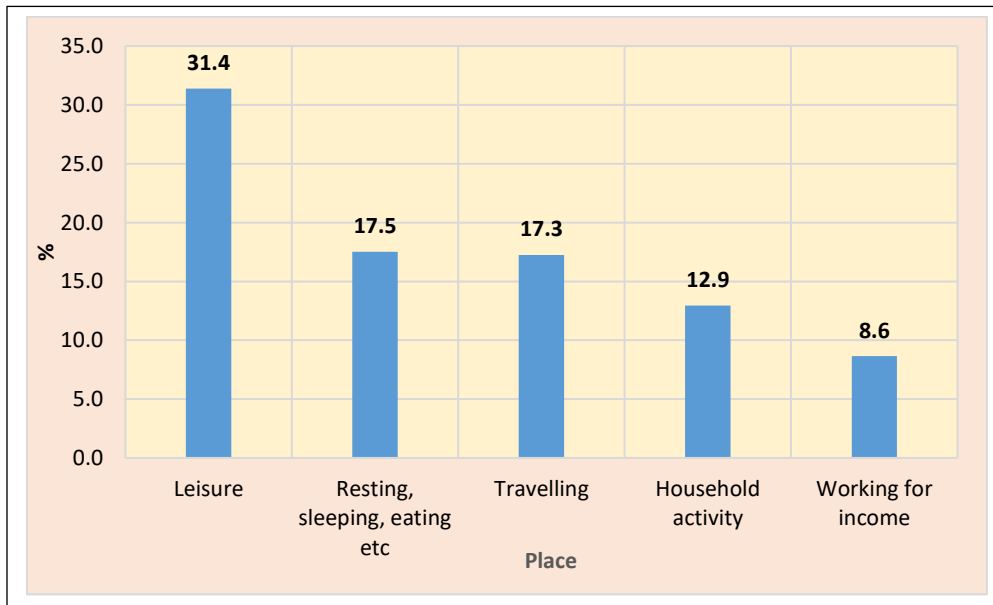
Figure 8.8: Leading places of occurrence of injuries by percentage



3/5th of injuries occurred at home followed by street/ road/highways (19%)

KK. Activity done at the time of injury

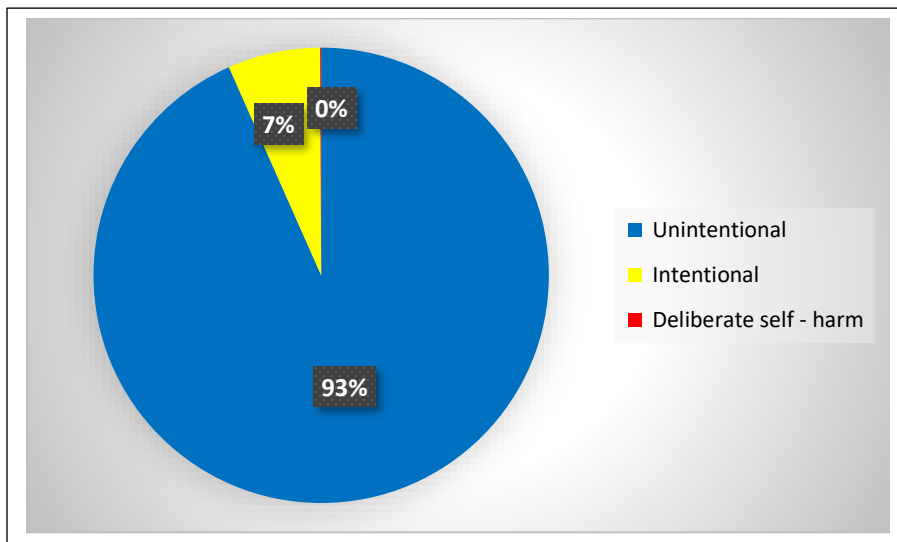
Figure 8.9: Leading activities done at the time of injury by percentage



Most injuries occurred while engaged in leisure activity (31%). About 60% of injuries occurred while engaged in vital activities (18%), while travelling (17%), while engaged in household activity (13%) and while working for income (9%).

LL. Intention of injuries

Figure 8.10: Distribution of intention of the injuries by percentage

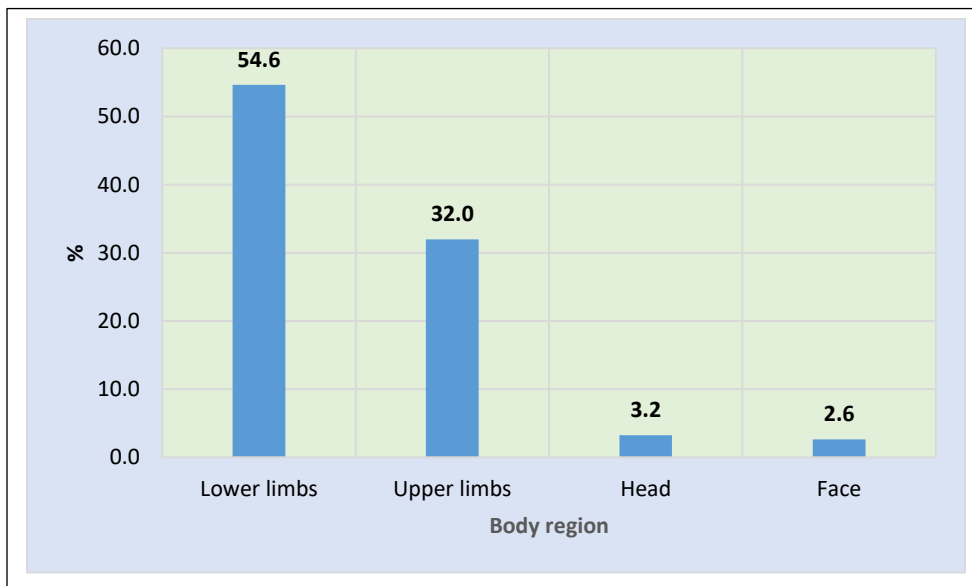


Most injuries were unintentional.

MM.

Body region affected

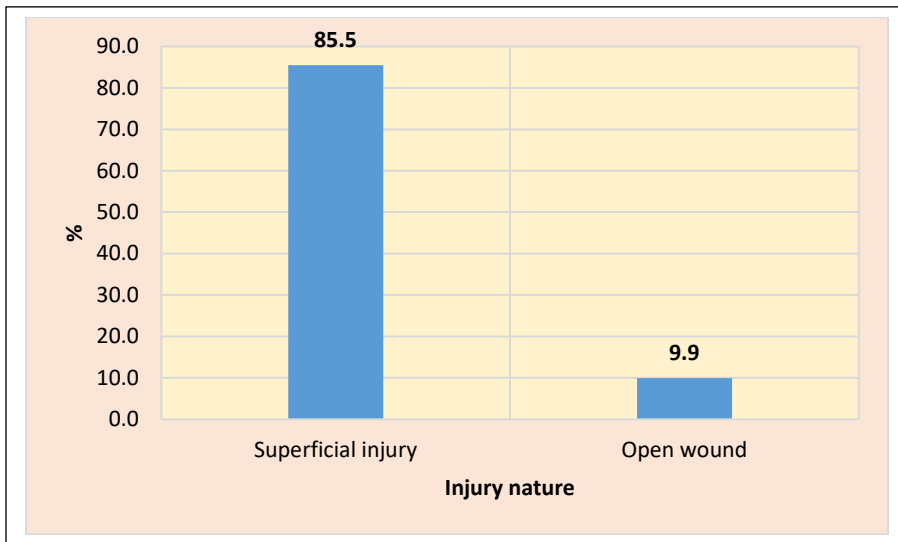
Figure 8.11: Distribution of injuries by affected body region by percentage



Limbs were mostly affected (Lower limbs – 55% and upper limbs – 32%) followed by head (~3%) and face (~2.5%).

NN. Nature of injury

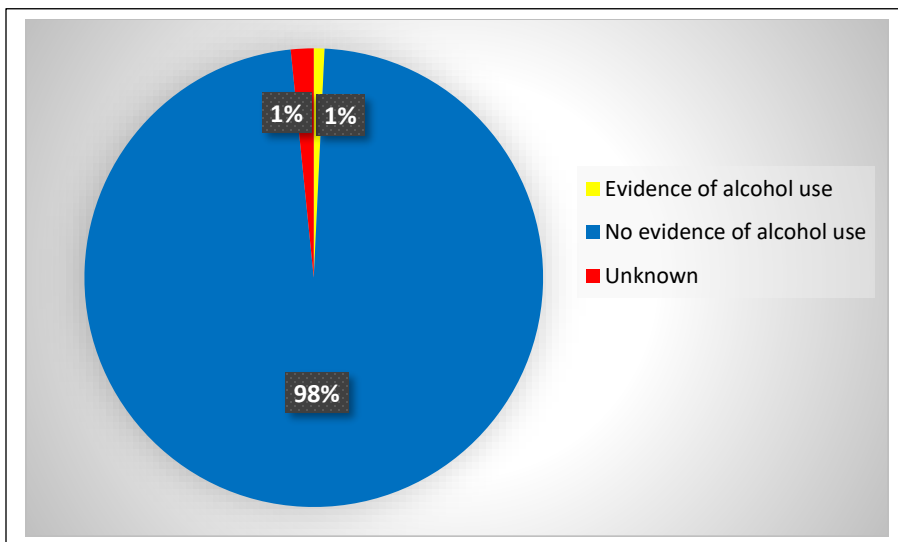
Figure 8.12: Leading natures of injury by percentage



85% of all victims had superficial injuries while 10% had open wounds.

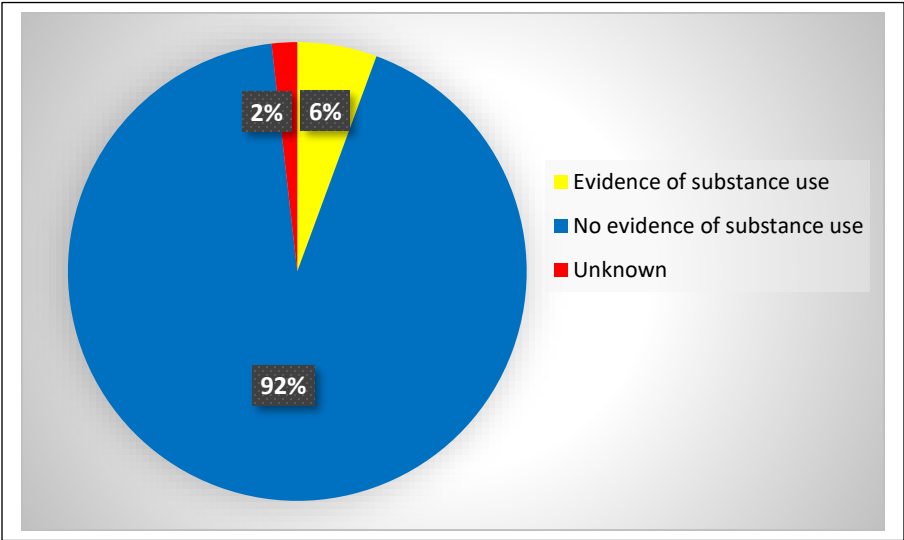
OO. Evidence of alcohol and substance use at the time of injury

Figure 8.13: Evidence of alcohol use by percentage



Almost all reported injuries had no evidence of alcohol use.

Figure 8.14: Evidence of substance use by percentage



6% of reported injuries had evidence of substance use.

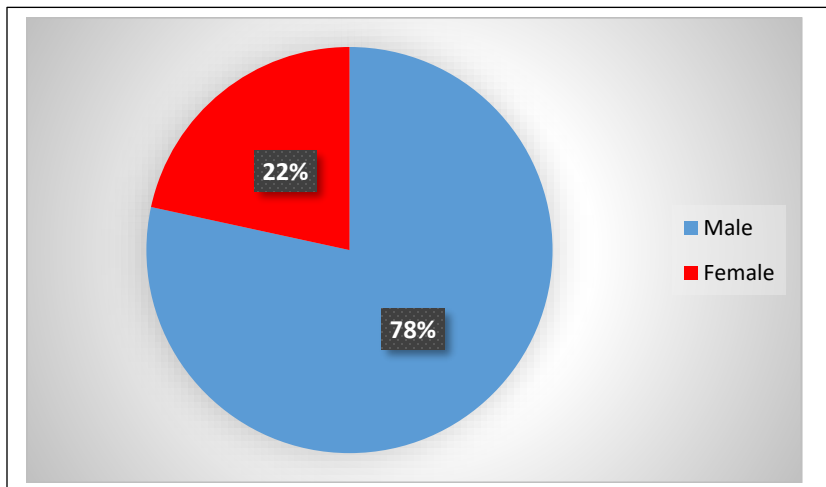
9. Deaths due to injuries

- About 4/5th of victims were males. However, both males and females were affected equally by fire related injuries
- The peak age group of the affected victims was 21 to 25 years.
- Majority of injury deaths occurred due to transport injuries (~30%) followed by Poisoning (~12%), Drowning (11.6%), Threats to breathing (7.3%) and falls (5.5%).
- In general, 3/5th of the injury related deaths were due to unintentional causes.
- Most of the transport injuries, drowning, falls, struck by object and electrocution were unintentional (>80%); most of the poisoning (89%), threats to breathing (82%) and struck by person (79%) were due to intentional causes.

764 deaths due to injuries were reported through national injury surveillance system in 2018. Therefore, below results were derived from the analysis of data on 764 deaths available through the system.

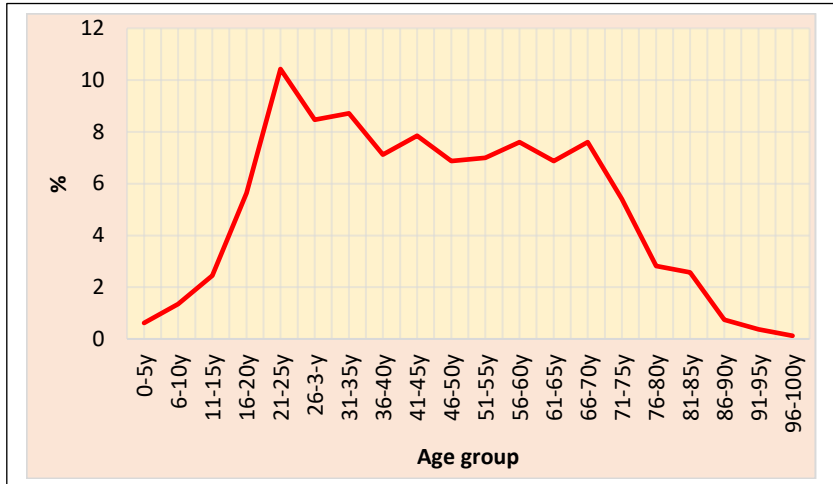
PP. Sex and age distribution of victims

Figure 9.1: Sex distribution of the victims by percentage



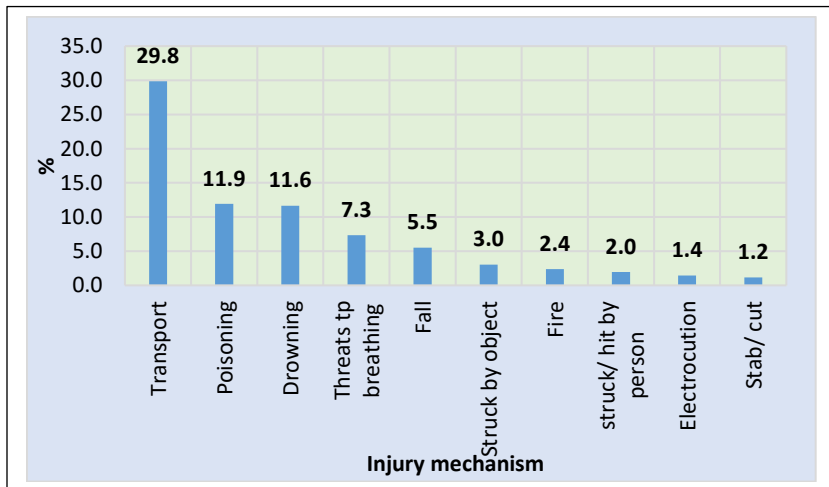
More than 3/4 of the victims were males.

Figure 9.2: Age distribution of the victims by percentage



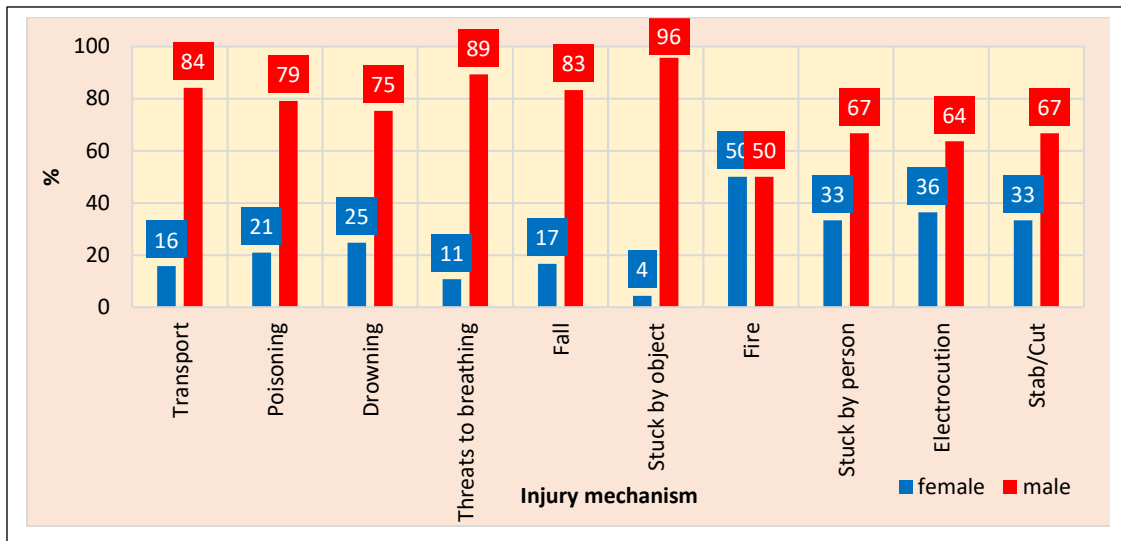
Even though most of the victims were from the age group of 21 to 70 years, the peak age group of the victims was 21 to 25 years.

Figure 9.3: Leading injury mechanisms related to deaths by percentage



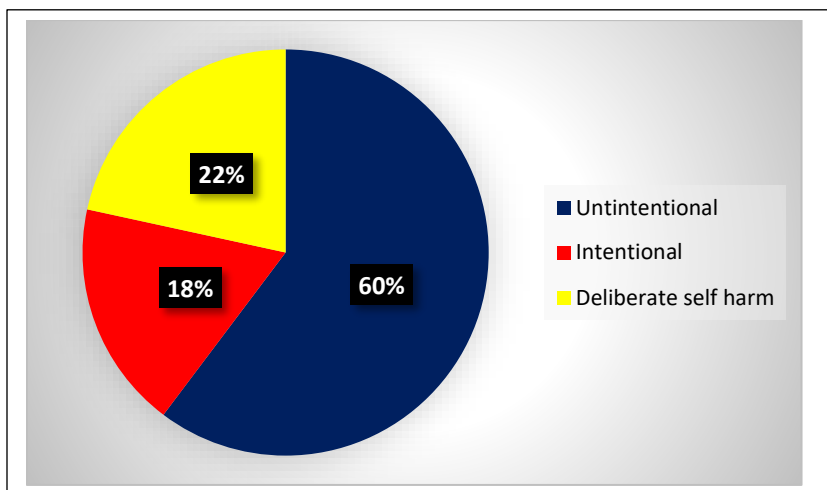
Majority of injury deaths occurred due to transport injuries (30%) followed by poisoning (12%), drowning (11.6%), threats to breathing (7.3%) and falls (5.5%).

Figure 9.4: Mechanism of injury related death according to sex by percentage



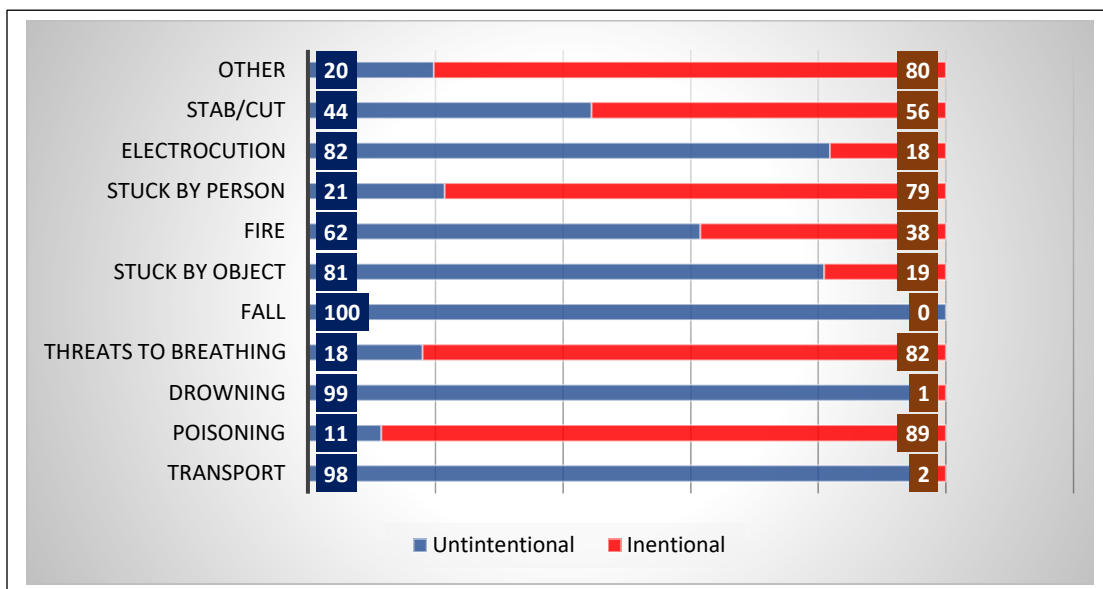
Except for the fire related injuries where both males and females were equally affected; males were mostly affected from all the other mechanisms of injuries.

Figure 9.5: Intention of injury related death by percentage



Majority were unintentional deaths (60%). However, deaths due to other intentional causes and deliberate self-harm were 18% and 22% respectively.

Figure 9.6: Intention* of injury related death by percentage according to selected injury mechanism



*Number of injuries due to intentional and deliberate self-harm were amalgamated as both are intentional injuries.

Even though most of the transport injuries, drowning, falls, struck by object and electrocution were unintentional (>80%), most of the poisoning (89%), threats to breathing (82%) and struck by person (79%) were due to intentional causes.

දුරකථන } 2698471
 தொலைபேசி } 2698475
 Telephone } 2698490

ෆැක්ස් } 2693866
 பெக்ஸ் }
 Fax }

විද්‍යුත් තැපෑල } postmaster@health.gov.lk
 இணையத்தளம் }
 www.health.gov.lk }
 E-mail }



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SUWASIRIPAYA

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 சுகாதாரப் போசணை மற்றும் சுதேச வைத்திய அமைச்சு
 Ministry of Health Nutrition & Indigenous Medicine

General circular No: 01 - 20 / 2016

All Provincial Secretaries of Health
 All Deputy Director Generals of Health Services
 All Provincial/ Regional Directors of Health Services
 All Heads of Decentralized Units/ Specialized Campaigns
 All Directors/ Medical Superintendents of Health Institutions
 All Medical Officers of Health
 Chief Medical Officer of Health – Colombo Municipal Council


National Injury Surveillance (NIS) System

Surveillance is a very important component in any successful prevention programme. It helps for continuous updating of information as well as for implementing programmes and to see the effectiveness and the efficiency of the on-going programmes. The current system of injury surveillance which is conducted through Indoor Morbidity and Mortality Statistics (IMMR) does not fulfil the requirement of gathering information for effective and proper planning of injury prevention activities and its management.

Therefore, in view of developing policies, strategies, guidelines and expediting the current injury prevention activities, Ministry of Health, Nutrition, Indigenous Medicine is going to implement an injury surveillance system in all government health institutions in Sri Lanka since, ...Q1...:.....Qb.....2016.

Details of the surveillance system are given below for your information.

You are hereby requested to bring contents of this circular to the attention of all the staff and ensure that the activities mentioned in the circular are promptly carried out.


 Mr. Anura Jayawickrama
 Secretary, Ministry of Health, Nutrition and Indigenous Medicine

Anura Jayawickrama
 Secretary
 Ministry of Health, Nutrition & Indigenous Medicine
 "Suwasiripaya"
 385, Rev. Baddegama Wimalawansa Thero Mawatha,
 Colombo 10, Sri Lanka.

Cc: Director General of Health Services

Phases of National injury surveillance system

1. Establishing injury information system
2. Conducting special information system for selected injuries
3. Conducting death reviews
4. Implementation of a feedback system

The case definition of an injured person to be considered in the injury surveillance

"Any patient with injuries who is attending any health institution for treatment due to injuries or any person with injuries dead on admission at any health institution"

Types of injuries considered

All injuries irrespective of the type should be considered. Hence, both intentional and unintentional injuries are considered in the surveillance system.

The implementation in the hospitals

Inclusion criteria of the patients

- All patients treated for the first time for any type of injury at the outpatient departments (such as Preliminary Care Units (PCU), Out Patient- Departments(OPD), Accident and Emergency units (A & E), Emergency Treatment Units (ETU) etc depending on the circumstances)
- All patients treated first time for any type of injury at the wards depending on the circumstances
- All injury related deaths brought to the health institution

Flow of Information (Annex 1)

1. For each patient treated at the health institution for any type of injury and for each victim who succumb to injury, an information of injury format should be filled (**Form 1 – Annex 2**)
 - ❖ The reference guide prepared will assist in filling the format (**Annex 3**)
2. For live victims, formats should be kept at each entry point (such as PCU, OPD, A & E, ETU, admitting officer, relevant wards etc depending on the availability) and attached to the PCU/ OPD/ A&E/ ETU chit and/ or to the Bed Head Ticket (BHT)
 - ❖ The format should not be removed from PCU/ OPD/ A&E/ ETU chit or from the BHT due to any reason
3. For victims who succumb to injury, formats should be kept at Judicial Medical Officer's (JMO) office
4. If a patient is admitted to a ward for further management after outpatient management, the format attached to the outpatient chit / BHT should be sent to the relevant ward along with the BHT
5. If a patient is transferred from one hospital (referred as hospital 1) to another hospital (referred as hospital 2) for specialized care, format should be sent to the hospital where the patient is transferred along with the transfer form. But the hospital 1 should keep a separate record of the transferred patient (marked as transferred to B hospital for specialized care) at the MRO's office
6. Formats filled at the wards should be sent to the Medical Record Office (MRO) along with the BHTs. All formats received by the MRO should be entered at the MRO's office
7. Formats filled at the outpatient departments and JMO's office should be collected daily by a team of officers accountable for NCD activities in the institution identified by the head of the institution. All formats collected by the team should be entered at the public health unit/ NCD unit/ injury surveillance unit or any other place identified for the activity
8. Quarterly return of injuries should be generated by each health institution according to the given format (**Form 2 – Annex 4**) and this should be sent to national Non Communicable Disease Unit, Ministry of Health, Nutrition and Indigenous Medicine, and relevant Regional Director of Health Services (RDHS) district units before 5th of the following month of the following quarter.

Officers responsible for filling the information of injury format

- Medical officer who is treating the injured victim/ JMO who is conducting the post mortem is responsible for filling the format.
- If a patient is admitted to a ward for further management after managing at the outpatient department, the rest of the format attached to the BHT should be filled/ completed by the medical officer who is treating the patient.
- If a patient is transferred from one hospital (referred as hospital 1) to another hospital (referred as hospital 2) for specialized care, the rest of the format should be filled at the hospital 2 by the medical officer who is treating the patient in the hospital

Supervising officers

Consultant or Medical Officer In charge (MOIC) or the Senior Medical Officer (SMO) of the relevant unit should supervise the related activities conducted in relevant ward or unit and the overall supervision and the responsibility at the institution will be held with the head of the institution

Injury surveillance team

For smooth functioning of the system, head of the institution should take necessary steps in establishing a team to look after NCD related activities including injury surveillance. The public health unit or the NCD unit could be given the responsibility under the direct supervision of the relevant unit head and also under the overall supervision of the head of the institution. If there is no such team or the capacity of such a unit is not enough to carry out the assigned activities, additional members could be considered to the team. Therefore the team could consist of MO NCD/ MO public health/ MO productivity and quality/ MO planning, Senior Special Grade Nursing Officer or a representative, 2 nursing officers, representative from MRO's office, any health worker with IT knowledge and skills.

Duties of the injury surveillance team

1. The team should assist the head of the institution for smooth functioning of the system in the health institution
2. The team should ensure
 - Availability of adequate numbers of information of injury formats at each entry point
 - Attaching the format to relevant outpatient chit or BHT
 - Completeness of the filled formats
 - Collection of the filled formats from the outpatient departments and JMO's office
 - Periodically entering the data into the system
 - Generating institutional summary
 - Quality control at the data capturing and data entry points
 - Inform NCD unit, Ministry of Health, Nutrition and Indigenous Medicine on any death reported due to injuries as early as possible
 - Sending a quarterly return to national NCD unit and to the relevant RDHS office

Implementation in the public health sector

Flow of information (Annex 1)

1. All Medical Officer of Health (MOH) should see the information of injuries sent from the health institutions relevant for the particular MOH division.
2. At the MOH office,
 - MOH is responsible for investigating and taking necessary steps to prevent further injuries where necessary
 - Public Health Midwives (PHM) and Public Health Inspectors (PHI) should assist the MOH for investigating and taking necessary steps to prevent further injuries where necessary
 - MOH may liaise with other relevant stakeholders to share the information to advocate them to prevent further injuries
 - MOH team should look for any injury taken place within the MOH division as much as possible. If such injury is not reported through the routine surveillance system (i.e. if the victim is brought to any curative health institution for treatment for the particular injury, consider that, the particular injury as a reported injury through the routine system) it should be reported to the relevant RDHS (or to NIHS) with a duly filled information of injury format (**Form 1 – Annex 2**)

3. MOH should prepare a summary of activities done for prevention of injuries according to the given format monthly (**Form 3 – Annex 5**).
 - Supervisory Public Health Inspector (SPHI) of the division should assist the MOH in preparation of the summary.
4. This monthly return should be sent to national Non Communicable Disease Unit, Ministry of health, and relevant Regional Director of Health Services (RDHS) on or before 10th of the following month.
5. MO NCD attached to each RDHS office and NIHS should send a quarterly report on reported injuries from hospitals and MOH offices according to the attached format before 20th of the following month of the following quarter (**Form 4 – Annex 6**) to relevant PDHS office and to the national NCD unit.
 - Institutional injury surveillance team should assist the district MO NCD to obtain relevant information from the institution

The procedure when a death is reported

If a death is reported at the hospital either before admission or after admission and if a death is reported to any MOH office, it should be informed to the national Non Communicable Disease Unit, Ministry of health on phone (011 2669599) or fax ((011 2669599) or to the following email address (acutencd@gmail.com) as early as possible preferably within 48 hrs (2 days) according to the attached format (**Annex 7**)

Monitoring of the system

Institutional level

Consultant or Medical Officer In charge (MOIC) or the Senior Medical Officer (SMO) of the relevant unit should supervise the related activities conducted in relevant ward or unit. Overall supervision and the responsibility of the institution will be held with the head of the institution

Medical officer of health (MOH) area

Overall supervision of the activities carried out in the MOH division will be held with the MOH of the area

District/ Regional level

Regional Director of Health Services (RDHS) of the district will be the overall supervisor of the activity in the respective district and district MO NCD will assist RDHS technically for smooth functioning of the system in the district

Provincial level

Provincial Director of Health Services (PDHS) of the district will be the overall supervisor of the activity in the respective province and Provincial Consultant Community Physician (CCP) / Epidemiology (in the absence of a CCP/ Epidemiology, the CCP/ Planning) will assist PDHS technically for smooth functioning of the system in the province

National level

Non Communicable Disease Unit, Ministry of Health, Nutrition and Indigenous Medicine will be the overall supervisor.