PANAMERICAN CONFERENCE ON ROAD SAFETY

The Health Sector Answers to the Challenge of Safer Roads in the Americas

Prepared by: Dr. Eugênia Maria Silveira Rodrigues, MD, PhD
Regional Advisor on Road Safety, PAHO-WHO/Brazil

Dr. Alberto Concha-Eastman, MD, MSc
Regional Advisor on Violence and Injury Prevention, PAHO-WHO/WDC

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SUMMARY

INTRODUCTION ........................................................................................................................................3
OPENING CHAIR ....................................................................................................................................3
OBJECTIVES OF THE MEETING .............................................................................................................4

PRESENTATIONS

Road Safety in the World and in the Americas

World Report on Traffic-Induced Injury Prevention with emphasis on world progresses and achievements, since its launching in 2004 ...........................................................................................................6
Traffic Safety in the Americas – progress and challenges ......................................................................7
Brazil’s experience in promoting road safety ..........................................................................................8
Involvement of the Ministry of Health in the prevention of injuries and deaths caused by traffic 8

Review of U.N.O. and World Health Organization (WHO) – What must be done? ...............................9

Strengthening of the Health Sector in specific attributions: Care of the victims, Research, Education and Information System

Alcohol and traffic accidents, the role of the health sector in prevention ........................................ 10
Hospital Morbidity due to traffic injuries ..................................................................................................13
Significant Progress – The Center for Disease Control and Prevention (CDC) efforts in Traffic Injury Prevention ...........................................................................................................................................13

How can we promote effective collaboration among health, traffic, transportation and other sectors?
The health sector perspective – the Mexican experience for the adoption of traffic policies, starting with the health sector ..................................................................................................................................................14
Perspective of the transportation/traffic sector : Costa Rica .....................................................................15

Health Sector – Non-governmental Organizations (NGOs) partnership

Global Forum on Road Safety – collaboration for Road Safety in Latin America and the Caribbean .....................................................................................................................................................17

Work experience in the Health Sector – ..................................................................................................17

Methodology for Costs of Traffic Accidents in Brazilian Agglomerations ........................................ 18

Contribution of the International Reconstruction and Development Bank (IRDB) .....................19

Contribution of the Inter-American Development Bank (IDB) ...............................................................19

REMARKS ON THE PRESENTATIONS CONTENT ..............................................................................20

RECOMMENDATIONS ..........................................................................................................................23

FINAL COMMENTS .................................................................................................................................25

NEXT STEPS ..........................................................................................................................................25

PARTICIPANTS .......................................................................................................................................26

ELECTRONIC REFERENCES OF PRESENTATIONS ........................................................................30

BIBLIOGRAPHIC REFERENCES ............................................................................................................31
INTRODUCTION

In the world as a whole, and in the Americas, traffic-induced injuries are a Public Health problem of great magnitude and transcendence. Its great impact on the population’s morbidity and mortality generates a high percentage of deaths and hospital stays, in addition to high hospital costs, material loss, social security and medical care expenses and, naturally, great suffering for the victims and their families.

Being well-aware of the importance of the theme, the Pan-American Health Organization (PAHO) held the Pan-American Conference on Road Safety in December, 2005, in which representatives from 16 countries participated.

OPENING CHAIR

PAHO/WHO Representative in Brazil, Horacio Toro Ocampo; Director of the United States National Center for Prevention and Control of Injuries and of the Center for Disease Prevention and Control, Ileana Arias; Director of the WHO Department for Prevention of Violence and Injuries, Etienne Krug; Representative of the National Council of Municipal Health Secretaries, Neda Figueiredo; Representative of the State Health Secretaries National Council, Julio Muller; Director of the National Transit Department, Alfredo Peres da Silva, for the Minister of Cities, Márcio Fortes de Almeida; Secretary of Health Vigilance, Jarbas Barbosa, for the Minister of Health, Saraiva Felipe.

Horacio Toro Ocampo, PAHO/WHO Representative in Brazil, wishes all successful work so that the theme of this conference may be duly dealt with, as a part of health, as part of a social problem, and, especially, as part of development in our countries. He highlights the importance of the presence of authorities and distinguished people from the Americas, experts on the topic of road safety. The presence of representatives from the World Health Organization and the Pan-American Health Organization shows the commitment that those organizations—together with the Ministry of Health and the Ministry of Cities—have with the theme. The opportunity to think and plan on the several aspects that may bring public policies forward in favor of citizenship, to exchange lessons learned and, especially, to convey to others what we deem as success as well as errors.

Alfredo Peres da Silva, Director of the National Transit Department of the Ministry of Cities, representing the Minister of Cities, Márcio Fortes de Almeida, highlights that the Ministry of Cities, aiming at the social area, in the scope of housing and sanitation, seeks and intends to develop this activity, in the area of the transit authority, also aiming at the social area, with great concern for the citizen’s interest and safety. This will only be possible with an integrated action, not only in the road safety scope but also in the areas of health, transportation and the regulating agencies—terrestrial and water transportation—as a government project, with a global plan for the decrease of traffic accidents.

Jarbas Barbosa, Secretary of Health Vigilance, Representative of the Minister of Health, Saraiva Felipe, states that traffic safety is a problem of great magnitude, both from the sanitation point of view as well as from the social and economic point of view, and it is the health sector’s double responsibility, on the one hand, to attend to those victims but not only to watch the growing needs of the traffic accidents’ victims passively. The health sector can provide information, surveillance, studies on the topic,
and has done so, in order to give support to the adoption of public policies that might – and there are some concrete examples that show the power of such measures to achieve a decrease in the occurrence of those events - save lives and contribute to the improvement of the population’s health standards. He reminds us of the importance of a stronger political advocacy, that traffic accidents are not accidents in their majority; they are predictable and preventable events. He stresses on the efforts made to try to use surveillance tools for the clarification and identification of trends. As regards to that, he takes the example of the exponential growth in the number of motorcycle accidents, as of the late ‘90s, and the fact that the decrease in the number of traffic accidents is not observed homogeneously in different regions in Brazil – a fact that can be explained by accelerated urban development and low supervision capability in some states. He comments on the advantages of the decentralization that occurs in Brazil in the areas of health and transit for local decision-making. He expects and wishes for progress in reflecting on this theme and, thus, for the possibility of improvement in collaboration between the sectors of transit and health because it has demonstrated to be beneficial and has promoted positive action to reduce the death toll and that of the traffic accidents and victims in our country and in the Americas as a whole.

OBJECTIVES OF THE MEETING

I. To define how the health sector can improve its commitment and responsibility for road safety in the Americas, in partnership with other sectors;
II. To contribute for better use of information;
III. To point out the need for better use of the resources in order to decrease the risk-generating factors, thus preventing the occurrence of traffic injury.
IV. To stimulate the creation and strengthening of national road safety councils, and to make them stronger where they exist;
V. To strengthen social participation;
II. To improve cooperation on this issue among countries;
VII. To form a regional alliance for this kind of technical cooperation;
VIII. To draft a final document with the content of the presentations, recommendations and conclusions.

Seventy representatives from countries, governmental and non-governmental organizations and international agencies participated in the Conference:

- Argentina, Bolivia, Chile, Costa Rica, the United States, Ecuador, El Salvador, Guatemala, Jamaica, Mexico, Panama, Paraguay, Peru, the Dominican Republic, Venezuela (15);
- Brazil– Ministries: Health, Cities and Labor, Science and Technology; Municipal Health Secretaries National Council; State Health Secretaries National Council; Institute for Applied Economic Research; Universities; NGOs; Private Sector representatives; Medical Societies and the Federal Psychology Council. (49)
- World Health Organization, Pan-American Health Organization, Global Road Safety Forum, the World Bank, the Inter-American Bank, FIA Foundation; (CDC), Atlanta, USA. (7).

The themes presented and discussed were:
- Road safety in the world and in the Americas. Review of the UN and WHO Resolutions. What needs to be done.
- Brazil’s experience in the promotion of road safety: Ministry of Health and Ministry of Cities.
How to promote effective collaboration among the areas of health, transit, transportation and other sectors: Mexico and Costa Rica.

- Health Sector – partnership with NGOs.
  Strengthening of the Health Sector in specific tasks:
  Care of the victims, Research, Education and Information System.
  - Alcohol and traffic accidents, the role of the health sector in prevention.
  - Hospital morbidity caused by traffic injuries, Brazil in 2003.
  - Significant progress: the CDC efforts in the Prevention of Traffic Accidents.
PRESENTATIONS

Road Safety in the World and in the Americas

World Report on Traffic-Induced Injury Prevention with emphasis on the world progresses and achievements, since its launching in 2004
Etienne Krug
Director
WHO, Department of Violence and Injury Prevention.

The problem of unsafe roads is huge, on a world scale. Every year, 1.2 million people die on roads all over the world. Between 20 and 50 million people are injured in the streets. Most of them become handicapped, at least for some months but sometimes for the rest of their lives. Most of those people who die or who are injured on the roads are called “vulnerable users”.

The first step to solve this is political decision, and it might be the most important step to generate action. The world report on the prevention of traffic accidents was launched on April 7, 2004, and it is the result of the joint work of WHO and the World Bank, and of their many experts around the world in trying to describe the problem and its possible solutions.

The report shows very clearly that the problem is huge on a world scale, but that the distribution of the problem is very unequal. The figures of the economic cost are, every year, 500 million dollars, on a world scale, but the human cost, the suffering, is not possible to express in figures.

The rates of mortality for traffic accidents in the United Kingdom, Australia and the United States show that those countries have achieved greater progress in reducing mortality in the streets.

The answers cannot be the same in all countries. The answer must be adapted to the type of problem found. The answers are different in different countries, but the principles are the same. After the launching of the report on a world level, more than one hundred ministers of health have designated focal points within their Ministries of Health to work on the problem, which was not done before. Many countries have begun to work on designating a coordinating agency; others are working on action plans. Still others have decided to begin with national conferences.

Some regions have begun to work on goals, on indicators. In Africa, a decision was made to reduce to half the number of deaths on African roads until 2015. Several countries have intensified their prevention programs: helmets in Cambodia, safety belts in China, etc. Data gathering has increased in many countries. Others are beginning work in pre-hospitalization services, such as in Mozambique. Finally, other countries have decided to work hard on road infra-structure, such as India. Certainly, many actions were being taken; not everything started last year, but there was incentive to more action.

On the level of the United Nations, great collaboration was initiated, as a result of last year’s effort (see U.N. resolutions).
Traffic Safety in the Americas, progress and challenges
Alberto Concha-Eastman –
Regional Advisor for PAHO/WHO on Violence Prevention and Road Safety.

Traditionally, traffic has not been seen as a health responsibility. In the entire world, the millennium objectives are being discussed nowadays. And if we achieve to reduce the mortality of those injured in traffic accidents, we will have contributed, somehow, for the improvement of the millennium’s objectives regarding to decreasing poverty and child mortality.

PAHO works closely with WHO. We do joint work to strengthen the activities in the region. PAHO has a series of partners worldwide; regionally, there are the OAS, bi- and multi-lateral organizations, NGOs, foundations, the private sector, so that the Organization’s inter-sector and political approach is actually clearly applied to the theme of road safety.

The Organization responds to the needs of the countries, not to the needs of the Organization. It becomes a forum for debates and discussions: this meeting is one such forum. There are other ways for technical cooperation, by means of specific mechanisms, and then it becomes a learning organization: learning from the experience of others.

From the 2004 meeting in Brasilia came out two documents that you have in your folder: “Road Safety: a problem of public policy in the Americas” and an extensive review that we carried out based on information gathered from countries participating in the meeting, a document with the magnitude of the problem. We proposed a classification of the countries in the Americas as: low risk, below 10; medium risk, between 10 and 20; and high risk, above 20. Most countries are between medium and high risk.

We are not concerned with “starting from zero” but with advancing in the construction of better information. There is a significant difference in the mortality rates per type of user in the region. It is amazing to see that, almost homogeneously, around 80% of the cases in each country are male and 20% female. It is almost a general trend in the Americas. Most rates and traffic problems are among middle-aged men at a productive age between 30 and 44 years.

In Washington, for the World Day, a declaration was signed for the PAHO Director, together with the World Bank vice-president and the deputy directors of the United States Health Service and Transportation Department.

In Brasilia, in 2004, we became aware that more is done than was supposed. There are many national councils or committees in different countries – Mexico, Venezuela, Costa Rica, El Salvador, Chile, Argentina, etc, have national councils. What is done is less than should be done, less than is expected to be done.

Some complementary recommendations to the World Report came out of the meeting last year: it was proposed that the member-countries define their reduction goals.

In Brasilia 2005, then, we wanted to identify means of contributing to fill those voids in the health sector, in order that we may progress.

One hundred and thirty million are estimated to have been killed in the region and one million two hundred thousand have been wounded, of whom we don’t know for sure how many have become incapacitated but we can state for certain that the figure is in hundreds of thousands. We must take such challenges upon ourselves very seriously.
and with a commitment that will lead us to answer to decrease these numbers, because this is preventable – everyone has said – and there is no arguing about that.

Road safety is another form of social iniquity; in general, the most vulnerable strata of the society are the most affected. In a presentation given in Brasilia, last year, it was stated that mortality is more significant in the less schooled strata of the population.

We have no information on costs, only a few isolated data from some countries, some cities, but we definitely lack information.

Bogotá is an example to show us that it is possible to have democratic recovery of the public space, with the resulting significant reduction of traffic victims’ mortality, in 1995, of 25 per 100,000, with an ongoing decline down to 8 per 100,000 in 2004.

**Brazil’s experience in promoting road safety.**

Alfredo Peres da Silva –
Director
National Transit Department Director, Ministry of Cities of Brazil.

In a meeting with the National Transit Council, the Minister sought to convey to the councilors his concern about the area of road safety, the citizen’s safety. We have in the National Transit Council representatives from the Ministry of Cities, which chairs it, from the Ministry of Transportation, the Ministry of Health, the Ministry of Science and Technology, the Ministry of Education, the Ministry of Defense and the Ministry of the Environment. Hence, the minister has requested that there be an integrated action, even in the action of parliamentary assistantship, towards acting jointly so that changes in the legislation could be expedited in order to ensure improvement in Brazilian road traffic.

**Involvement of the Ministry of Health in the prevention of injuries and deaths caused by traffic**

Otaliba Libânio de Moraes Neto –
Director
Department of Analysis of the Health Situation/Secretary of Vigilance in Health – Ministry of Health of Brazil.

In Brazil around 33,000 deaths – result from road transportation accidents.

In relation to hospitalization, Brazil’s United Health System is responsible for about 70% of the hospital care. 8.1% of the nine million hospitalizations result from external causes, 15% of which are caused by road transportation accidents.

Pedestrians stand out as the main victim; and there has been a significant growth trend in the number of deaths among motorcycle riders, especially for men.

There is an effort to identify the risk differences, be it in relation to the geographic area or be it with regard to age, sex, but also by introducing components of the differences among ethnic groups and race groups. The greatest risks are for black and mulatto pedestrians. People with fewer than four years of schooling, independent of their race, have a higher risk as compared with those with more than four years of schooling. These data are closely linked to socioeconomic condition, but not only.

**Review of the U.N.O. and WHO Resolutions. What must be done? Etienne Krug.**

In 2004, for the first time in the history of the United Nations, the General Assembly decided to talk about road safety. Rarely does the General Assembly talk about health: only subjects like malaria, tobacco – imagine – and road safety have reached this level, which gives significant weight to the topic.

It is appropriate to remember that the resolutions, both on General Assembly and World Health Assembly levels, are not legal documents that compel the governments to
carry out the activities proposed. They are important guidelines and commitments taken up by the governments.

On April 14, 2004, the United Nations resolution called *Improving Global Road Safety* was adopted. It had three major points, the first of which was that the nations that adopted it – and it was unanimous – took note of the recommendations in the World Report on Traffic Injuries Prevention. The second point was that the WHO was invited, in close collaboration with the regional United Nations committees, to have a coordinating role within the United Nations system. The third point summoned towards a strengthening of international cooperation on the topic.

The following month, in May, the World Health Assembly adopted a resolution on the topic of road safety. For the first time since the ‘70s, this topic was addressed in that meeting. This resolution was called Road Safety in Health, number 57.10.

The most important point of this resolution was that the World Health Assembly accepted the invitation of the United Nations General Assembly to perform the role of coordinator. And, secondly, there were several recommendations made by the WHO members to the governments: first, to include road safety in their public health programs; second, to carry out a study on the road safety situation and on the traffic accidents on a national level; third, to prepare a national plan of action; fourth, to create a national agency for coordination, in the event that it did not exist; fifth, to improve the emergency and rehabilitation services for the victims; and to implement prevention interventions focused especially on five risk factors of significance: safety belts, helmets, alcohol, high speed restriction and infrastructure changes. Hence, on the level of governments, at present, regarding health, at least a focus on those priorities has been adopted.

An inter-agency group was created to try to improve international collaboration on this topic. This group began with around thirty agencies and now it has more than fifty, which are members of this collaboration group, on United Nations level. It was made accessible to other groups, such as the NGOs that represent the victims, to some governments that work on an international level, to donors, and also to some public sector representatives.

The resolution that was adopted on October 26, 2005 was called “A60L8 Resolution” – Improving Global Road Safety. This resolution has more content than the first one. The resolution invites the member-states to implement the recommendations of the World Report and to focus specifically on the five risk factors and to establish a coordinating agency. The resolution also calls on the WHO and on the regional committees to organize, together, the first “United Nations Week on Road Safety”. And it invites the member-states and the international community to acknowledge the third Sunday of each year as the world day to remember the victims of unsafe roads. This means that the effort, on an international level, is gaining momentum, it is being recognized and, increasingly, this kind of activity is being accepted.

The date for the First United Nations Week on Road Safety will be April 23 – 29, 2007. The theme will be “Young Users”. It concerns the young victims and the young drivers. Therefore, it has a broad scope. Clearly, we know that this group takes up a large proportion of the victims. It is also very important for those who are involved in causing accidents and thus deserve attention.

What is expected from this week, a little like the World Health Day, is that it be celebrated in all countries in the world, that each government decide what is more useful to put forward in the country’s national agenda, on the topic, at this time. But there should be activities of the victims groups, the NGOs, the experts, the governments, in order to achieve progress of several points in the agenda during that week.

As additional comment in answer to what has been brought up, the idea is not to impose that, in every country, health should have the role of coordinator. It is up to each
country to determine who will be the best coordinator. It may be health, or not. It seems ideal that the coordination be at the level of the Prime-Minister cabinet, or the President’s, or similar, in order to ensure access to all. A good coordination is not that which tries to do everything, but that which encourages all to perform their roles. This is what is expected to be stimulated on the national and international levels.

Finally, it is important to bear in mind that all governments have signed and adopted these resolutions and that should be kept in mind, for there are changes in personnel with the government changes and people will not know what resolutions were adopted last year. It is our role to remind them of those commitments.

**Strengthening of the Health Sector in specific attributions: Care of the victims, Research, Education and Information System.**

**Alcohol and traffic accidents, the role of the health sector in prevention – Maristela Monteiro – Regional Advisor on Alcohol and Substances Abuse, PAHO/WDC.**

In the Americas, alcohol shows up in the total figures as the major risk factor for diseases, over tobacco. In the poorer countries, alcohol appears as the main risk factor for diseases – over low body weight, malnutrition and tobacco. Putting all countries together, we will still see alcohol in the top position as a risk factor for diseases.

Among men, 13% of all mortality in the region is related to alcohol consumption. Among women, it is 3.4%, and on the whole, it is 8.8% - almost 10%. That is to say that one out of every ten deaths in the region is caused by alcohol. The first causes of mortality are precisely due to intentional and non-intentional injuries, in which traffic accidents are included. This suggests that there are areas in which intervention can occur, in terms of public health, with policies aiming at reducing consumption by the population in general and as to standards of excessive consumption.

More effective policies:
- Minimum age for purchase of alcoholic drinks – i.e. in general, 18 years of age, in most of the region’s countries;
- Government monopoly for the retail sale of alcoholic beverages;
- Restriction of hours or days in which alcoholic beverages are sold;
- Restriction of sale spots;
- Tax on alcoholic beverages to increase prices in relation to other products;
- Checkpoints for the control of alcoholemia – or sobriety – along highways;
- Lower levels of alcoholemia required – the lower the better;
- Administrative suspension of the license or gradual granting of a driver’s license to new drivers;
- Brief interventions for risk consumers, those who are not dependent; interventions that may be carried out within the primary health sector – they are effective and have impact on the population.

The treatment of alcohol dependence is effective, but on an individual basis. On the population level, since the number of alcohol dependent people in the population is smaller than the number of people who occasionally drink in excess, the impact of treatment, even if well done, is small in terms of public health. But certainly, treatment of alcohol dependence should exist in the whole health system of all countries.

The least effective practices?
- Voluntary code for practice in bars: people who serve alcoholic beverages will not continue serving drinks to those who are already
intoxicated – there is no evidence that this will work, on the public health level.
- Promoting activities that will not include alcohol.
- Education, in schools and universities, on the malignant effects of alcohol and on the evils it causes – there is no result on the medium or long term. It does not delay the initiation of consistent use, nor does it decrease consumption among young people who already drink.
- Public service messages – they have no impact, they compete with massive advertising by the alcohol industry.
- Warning tags.
- Use of designated driver or taxi service that will take people home. They are not bad. On the whole population level, the number of people who would be necessary to have impact with this kind of measure is large and not always available. In addition, what the population usually interprets as the “designated driver”, when friends go to a party together, refers to the one who is “less drunk” driving everybody home – which puts everyone at risk.

Among the most effective practices, we might highlight the checkpoints for controlling sobriety, which work mainly by dissuasion. Its cost is relatively moderate and it reaches the population as a whole. At random checkpoints for alcoholemia, haphazard checking by the police will simply stop someone and check. There is a lot of scientific evidence that this also works to prevent fatal and non-fatal accidents and to decrease the alcohol-driving relation.

Lower levels of alcoholemia are a very effective measure (a minimum of 0.08 is the recommendation). For young people, sometimes zero tolerance is promoted.

The administrative suspension of the driver’s license is also a relatively effective measure at a moderate cost. The granting of the gradual license (restriction to driving alone at night, or on weekends during the first months after obtaining the license) is another restrictive measure.

These measures are more effective because they produce systematic decreases and, in the long run, that will vary between 5 and 30%.

Training programs, in themselves, are not effective, but they may have some value if they are included in a more general program that will offer treatment when the person is really alcohol-dependent, with the suspension of the license and penalty if recurrent.

Current situation of policies in different countries as regards to alcoholemia:

- Dominican Republic – there is no limit;
  - 0.0-0.03% - Costa Rica, Guiana and Panamá;
  - 0.04-0.06% - Brazil, Argentina, Chile, Ecuador, Jamaica and Venezuela;
  - 0.06 or over in the remaining countries.

Suspension of the driver’s license only occurs in Costa Rica and the United States; no other country adopts this measure.

What can be done?

- Systematic enforcement of the law. The changes in the legislation and in how it is interpreted can bring about great benefits: sometimes it is in the definition of what is alcoholic beverage or in the definition of a minimum limit for alcoholemia.
- Education of the public not on the evils of alcohol, but in support of the legislation changes and in support of community actions, of NGOs.

**What can the health sector do?**

- update the education of health professionals to have a perspective of alcohol consumption in public health;
- stimulate research on the relation between accidents and alcohol consumption: the data we have are still from the U.S.A., Canada and some other countries that have data but whose gathering is not systematic and that don’t have local studies on the relation.
- include alcohol consumption indicators in the national vigilance system – sanitation vigilance.
- measures of national policy that combat or decrease the general consumption of alcohol by the population will also have effects on the alcohol-traffic accident relation.

PAHO has been working to develop a regional strategy and to help countries to implement more effective policies.

**Hospital morbidity due to traffic accidents**

Vilma Pinheiro Gawryszewski
Coordinator
Accident and Violence Prevention, Sao Paulo State Health Secretary.

The data source is the hospitals information system. In Brazil, most of the hospitalizations are cared for in the public health system. We cover about 85% of all hospital care in the United Health System, the public system. This varies according to the state. Some states with higher income have a larger share of the population using the private system. Our data bank has about 11 million patients entering the hospitals every year.

In 2003 – the data are from 2003 – there were 11 million and 600 thousand hospitalizations, of which 6.5% - almost 750 thousand – were due to external causes. Of these 750 thousand hospitalizations for external causes, most – 650 thousand – were caused by accidents, for non-intentional injuries, and 114,189 were caused by transportation accidents.

The transportation accident victims, on average, have a longer time of permanence in hospital than the total of external causes, but their time is shorter than that of the patients that go into hospital for natural causes.

The rate of mortality for transportation accidents, regarding in-hospital victims, is greater than that of in-hospital patients for all other external causes and also for natural causes, which suggests that transportation accidents are accidents that cause very severe injuries. As regards to the average cost of hospitalizations, the average cost of transportation accidents is higher than that of external causes, of victims in hospital care due to all external causes and also for natural causes. It is a victim that remains in hospital care for a shorter period of time but whose lethal condition is higher and whose treatment requires higher cost too. The transportation accident victims have a cost/day average higher than those of other external causes and of natural causes.

The issue of public expenses in a country like ours, whose income is not so high, is quite significant. The importance of accident prevention, not only to diminish mortality and avoid sequels but also in the sense of decreasing public expenses with
Significant Progress: The CDC efforts in Traffic Accident Prevention

Dr. Ileana Arias
Director.
NCIPC/CDC

The mission of this department in the Center for Disease Control – CDC – is to reduce the number of deaths connected with non-intentional injuries and violence and to reduce the hospital costs and other consequences of those injuries.

In the United States, the traffic injuries are responsible for 42,000 deaths annually, being the major cause of death until 44 years of age with great impact on children and teenagers. There are about 400,000 hospitalizations annually associated with traffic accidents, the third cause for care at the Emergency Units and responsible for 50 to 60% of head injuries and injuries to the spine. Approximately US$150 billion is spent on those treatments every year.

From a Public Health perspective, the CDC works on vigilance activities to learn about the problem, identify risk and protection factors, develop and assess prevention strategies, disseminate information and support programs with the community. Young drivers or passengers, pedestrians and individuals over 60 years of age present a greater risk of traffic-sustained injuries. The CDC gives priority to its actions among these groups. It works to identify the risk factors for each of these populations and age groups and to build prevention strategies based on that information.

The CDC is interested in working with other countries, bringing resources to their aid. It is also a good idea to learn about successful experiences in other countries and to adapt them to our own.

One of the projects that we have been developing is injury vigilance at emergency hospitals, specifically traffic sustained injuries, with information on the use of alcohol and the type of vehicle involved. We have been working with Nicaragua, El Salvador, Colombia, Guatemala and Honduras, standardizing data gathering in the different countries and services to enable a comparison amongst them. We encourage the use and dissemination of that information. We have identified and supported effective prevention programs that use those data.

We have concluded that gathering data at emergency units is possible, that the health authorities are interested in gathering these data and in using them to develop prevention policies. For example, Nicaragua has developed a cyclist prevention plan. Part of this work was to develop a training program for professionals in those emergency units.

How can we promote effective collaboration among health, traffic, transportation and other sectors?

The health sector perspective - the Mexican experience for the adoption of traffic policies, starting with the health sector

Mr. Arturo Garcia Cruz, Mexico
National Center for Accident Prevention, Mexico Health Secretary.

Progress since the publication of the six recommendations in the World Report on prevention of injuries sustained in traffic:
- In early 2005, the establishment of State Councils was completed in 31 states of the federation and in the Federal District, with their
respective committees in these variables – home, school, streets, traffic, work, sport and recreation.

- The following educational activities were carried out: the content in free textbooks on accident prevention by age group, disseminated in medical units as part of the strategy for promoting health. Campaign for accident prevention aimed at the population in general, whose objective is to develop an awareness of the idea that accidents do not occur accidentally, caused by destiny.

- We participated in the advisory committee of the World Health Organization in celebration of the 2004 World Health Day in Geneva, Switzerland.

- We have participated in meetings to define policies and strategies for cooperation regarding the prevention of traffic accidents, with governmental and non-governmental institutions and organizations.

- The project of national accident accounts was developed in Mexico, which will enable us to know about the economic impact of accidents in the health sector – we still don’t know about the costs.

- The road safety Atlas in Mexico, developed by the Pan-American Health Organization, with the support of the National Center for Accident Prevention, the Regional Epidemiology Directory and the Geography Institute of the National Autonomous University of Mexico. The Atlas objective is to be a basic cartographic input for analysis, attention and prevention of traffic accidents in Mexico.

- In terms of legislation, the publication of an agreement on several protection measures to decrease the occurrence and the impact of traffic accidents was negotiated.

- Systematization of pre-hospitalization care at emergency units was initiated, with the implementation of a model of pre-hospitalization care in some states.

Organizations like the Mexican Health Foundation and the Social Research Foundation have been especially important in their support and incentive to measures aimed at preventing road accidents and evaluating their impact.

**Perspective of the transportation/traffic sector: Costa Rica**

**Mr. Roy Rojas**  
Executive Officer  
Road Safety Council – COSEVI – Costa Rica.

The scenario in which we have conceived of the road safety theme is one that thinks of the social process as an interaction of three factors – the fleet, the road and the environment – the human factor is influenced by the determinants of culture, policy, economics, technology and socialization of the countries.

The approaches must be whole, multidisciplinary, and inter-sector. It is a subject of rights, of life quality and of citizenship building. Likewise, one should work from the start with and for the population.

Costa Rica is a small country, a very friendly country, with four million inhabitants, of whom nearly one million are migrants from our neighbor country, Nicaragua. We have a fleet of 1.1 million vehicles, with a growth rate of 171% since 2000. We have 29,000 kilometers of roads, 7,000 of which are tarmac and 22% of those are in good condition. This is a high risk scenario and, starting from exposure determinants, Costa Rica has high exposure.
Council for Road Safety

This is an organization with maximum non-concentration within our country’s public framework. It is 27 years old. It has a road administration law that originated it and provides on its organization; it operates the general transit law. It has funding of its own, an inter-sector board in which the health sector participates. It is the dean of road safety in Costa Rica and, in spite of the fact that it is in the transportation sector, it connects all other sectors: the judicial, insurance, health, education and the technical parts of transportation and infrastructure.

Public policy landmark

Public policy should promote integration and participation of the social actors in the political process. It should be susceptible to a very precise, simple evaluation control which originates concrete actions. It should articulate, align international, national and local policies.

We have been working in a process of regulating our drivers’ accreditation, by which, being a driver must be a privilege, not a right.

The Road Safety Council allocates 10% of its budget to the towns for them to develop road safety programs and projects.

Actions carried out

- Technical vehicle check-up
- Strengthening and training of drivers
- Norms regulation for feedback-reflection on freight vehicles
- Strengthening of the transit policy. The transit police in Costa Rica belongs to the transportation and public works sector. A greater control on the topic of speed, on drivers under the influence of alcohol and other drugs has been generated.
- Road brigade, crosswise, official incorporation of the topic of education and road safety, from preschool to the end of middle school.
- Pedestrian campaign focused on migrants.

Results

In Costa Rica, 76% of the drivers in 2003 were not wearing safety belts. After the campaign, 82% and their passengers wear safety belts.

Reduction from 17.1 deaths per 100,000 inhabitants in 2000 to 14.06 in 2004, as we stated as our objective in the National Plan.

Lessons learned

- Political support to road safety
- Existence of public policies
- Ongoing national plan that follows results by a supervising road safety institution
- Self-supported financing source
- Organic private enterprise development
- Recognition of the problem as a public health problem but also as a complex social problem
Transit police as an executor unit of the Road Safety Council, direct coordination by the organism that oversees infrastructure and public transportation

Information system under development, a geo-reference system in “.net” format

Non-concentrated local level road safety, allocation of funds

Legislation focused on public health

Communications oriented towards the building of a civil culture.

**Health Sector – NGOs partnership**

**Global Forum on Road Safety. Collaboration for Road Safety in Latin America and the Caribbean –**

*Dr. Mark Rosenberg*

U.S.A.

How can we change knowledge and research into action for Latin America and the Caribbean?

Taskforce works with: Regional Economic Commission for Latin America – CEPAL; National Traffic Safety Commission; FIA Foundation; Inter-American Development Bank; Pan-American Health Organization; and the World Bank.

The United States are not doing enough. Mortality rates due to traffic accidents in the U.S. and in high income countries are diminishing. In other countries, like in the Middle East, Africa, Latin America and Asia, they are increasing. The reason for such discrepancy is that, in the U.S., the events involve occupants of motor vehicles who are protected by mechanisms like safety belts and airbags. In Kenya and in Vietnam, those involved are vulnerable motorcyclists, cyclists and pedestrians.

There are increasingly more cars in the streets and the number of deaths among the vulnerable users is increasing in most countries. Injuries and sequels are much more frequent and deaths and the impact on the families, the community and the health system is overwhelming. This is foreseeable but preventable. It is a public health problem, a problem of the transportation sector, of the legislation, of education, of urbanization, funding, development and social justice. It is a major task of all to create a need for road safety so that it is dealt with as a priority by politicians, to put a stop to this epidemic.

The transit system in Latin America and the Caribbean is designed to produce thousands of deaths every year – every system is designed to produce exactly the results it does – it is not possible to accept any of those deaths. This must be changed.

**Work experience in the Health Sector – learning experiences and ways to improve.**

*Eduardo Bertotti*

Instituto de Seguridad y Educación Vial (ISEV)

Argentina

The Traffic Security and Education Institute (ISEVI) is a private center created in 1985 as a function of the need to have an organism to study and research traffic, transportation, education and road safety, whose objective is to perform advisory action, technical assistance and qualification in the public and private sectors.

For the ISEVI, a traffic accident is something undesirable. Logomarca represents three basic aspects regarding transportation safety: the human factor, the environmental factor and the vehicles. ISEV is made up of the Department of Justice, Traffic
Methodology for Costs of Traffic Accidents in Brazilian Agglomerations

Ieda Maria de Oliveira Lima

Since 1998, IPEA has followed a line of research to quantify the costs of external traffic causes, beginning with “urban areas traffic jams”, which developed from 1998 to 2000.

Methodology

What is a traffic accident?

It is an event that occurs in streets and roads, sidewalks included. This was a great progress, from the conceptual point of view, i.e. we consider traffic accidents the accidents occurred with people without the involvement of vehicles. And, evidently, it results from the transit of vehicles and people, with ensuing human and material damage – thus involving collisions, crashes, flipping-over, falls, etc.

We defined the types of accidents:
- with death: accidents with at least one death were classified as accidents with fatal consequence;
- with victim, were the accidents with at least one injured person, without death;
- without victims, the accidents without dead or injured.

As to the people involved, we divided the accidents as:
- involving vehicles; and
- not involving vehicles, as is the case when pedestrians or cyclists fall.

The cost components considered were: damage to property; medical/hospital costs; costs with cessation of production or income; and other costs, such as police attendance, judicial suits, traffic jams, etc.

The main results of this project were that the total cost estimated for urban agglomerations, in 2003, in reais, for April 2003, was R$5.3 billion, thus distributed: 3.6 in urban agglomerations and 1.7 in other urban areas. The statistical sample allowed us this extrapolation, including other urban areas. These costs were divided into: 43%, the largest costs, for cessation of income/production; 30% in damage to property; 16% in medical/hospital care costs; and 11% in other costs.

The records represented 93% of the fleet being responsible for only 7% of the traffic accidents with victims, while motorcycles represented 29% of the fleet and were responsible for 71% of the accidents with victims.

The results of this project generated several recommendations for public policies, which we summarize as: priority in reducing the number of traffic accidents with victims; specific policies for motorcycles; actions aimed at pedestrian circulation; improvement of information on traffic accidents; and improvement of the national list of vehicles, which, although it was a significant source, evidently still presents some problems.

Contribution of the International Reconstruction and Development Bank (IRDB)
The World Bank has been working on the promotion of traffic safety for over twenty years. Nowadays, it is reviewing what has been done and it proposes a new way of working, considering each country’s national structure and culture.

The World Report highlights that the low and medium income country’s capability of working with road safety is insufficient. What is done is not measured, interventions are fragmentary and countries don’t focus on results. We have resources to support initiatives designed to improve those deficiencies, to help countries evaluate their capability of improving road safety, so that countries learn while developing projects. Vietnam and Iran are examples of inter-sector projects that we are financing towards improving areas with great incidence of collisions.

The objective of those resources is to strengthen the defense of the issue, on a world scale, and the coordination of actions to accelerate the transfer of knowledge to the low and medium-income countries, as well as to promote infra-structure solutions and to make the road safety of those countries better. The World Bank contribution is US$5 million for such projects.

Contribution by the Inter-American Development Bank (IDB)

Arne Paulson
Inter-American Development Bank – IDB

IDB works similarly to the way the World Bank works. We finance transportation projects in which the component of safety is also very relevant. There is a study in Lima, Peru, which is an example of that.

The activities needed are not restricted to the transportation sector; they include health, care and one of the most important issues to begin working with – the data and the information system, in order that financing priorities may be established.
HIGHLIGHTS OF THE PRESENTATIONS CONTENT.

Causes of traffic injuries
- ways of planning transportation and displacement;
- excessive speed;
- alcohol drinking;
- poor visibility for pedestrians;
- non-use of crash helmets, safety belts and special car-seats for children;
- vehicle safety; and
- post-accident attendance to victims - existing and non-existing services, emergency rescue, rehabilitation of the handicapped.

Risk factors according to life cycles

Children
- non-use or incorrect use of car-seats or safety belts;
- distraction; and
- greater vulnerability of children as passengers of vehicles, bicycles and as pedestrians.

Adolescents
- inexperience (skills, behavior);
- non-use of safety belts;
- alcohol drinking;
- excessive speed;
- distraction;
- risk attitudes;
- use of bicycles; and
- being male.

Adults
- non-use of safety belts;
- aggressive driving;
- exposure to traffic;
- alcohol drinking;
- tiredness;
- excessive speed;
- distraction;
- being a pedestrian; and
- being male.

Health promotion actions and intersector articulation
These actions should occur among the several government sectors, just as by direct initiative from the media, the civil society and the private sector. It is important to build a strategic plan, both operational and financial, that will ensure effective administration and leadership, enable exchange of knowledge on successful experiences and practices, and also project follow-up and evaluation.

The role of the Health Sector

The Health Sector has a major responsibility – not the only one, but the main one – in dealing with this issue, in its function of data gathering and information organization, as a frontline in its contact with the conditions of the fatal accident victims, as well as with the non-fatal ones. The institution can also contribute to support investigation of the causes of the problem; and in the scope of prevention, it can work in promoting changes of user behavior – consumption of alcohol, helmet, safety belt and children car seat use, for example.

The Sector has an important role in evaluating interventions whose impact is often unknown and in contributing to the construction of national policies to face the issue. It is the Health Sector’s duty to improve the services rendered to the victims in their care and rehabilitation, not only regarding their physical condition but also their psychological welfare; and in advocating for the social magnitude of traffic accidents, seeking likely answers to cope with the issue.

The Health Sector should play a protagonist role in the process and not only in the care of medical assistance problems and costs caused by these accidents to the public system.

Legislation

All of the countries in the Americas have more or less efficient legal provisions that should be permanently revised, enforced in a responsible, consequent, and hence effective manner.

Brazil is an example of this attitude, according to which the implantation of the National Transit Code of 1998 is a landmark in the reduction and prevention of traffic accidents in the country. Thanks to a series of measures provided for in the Code, such as the mandatory use of helmets for motorcyclists, safety belts for drivers and passengers, higher fines for infractions and cumulative points meaning suspension or loss of the driver’s license, among others, we have determined that there has been an effective reduction in traffic accident mortality in Brazil.

Information system.

An information system is an excellent diagnostic tool and an important subsidy to the implementation and evaluation of public policies. In addition to the hospital mortality and morbidity information systems, vigilance of injuries in emergency wards, specifically of traffic-induced injuries, can make information available, for example, on alcohol drinking and on the type of vehicle involved in a crash, which greatly contribute to the system.

An experience to consider is that of the CDC in Nicaragua, in El Salvador, in Colombia, in Guatemala and in Honduras. Their standardization in data gathering for services rendered to the accident victims has allowed for a comparison. In addition to encouraging the use and dissemination of information, the work promoted by the organization has enabled identification and support to effective prevention programs. CDC has concluded that data gathering in emergency wards is possible, considering the interest that arose in the health authorities towards their utilization in designing
prevention policies. For example, Nicaragua has developed a cyclist accident prevention plan.

An information system should articulate and integrate with the several data sources – Health, transit authority, Justice, Human Rights and others. In Brazil, in the scope of the inter-agency network for health information, a specific work group was composed with the objective of analyzing the several data sources consistency, building and standardizing appropriate indicators for the monitoring and vigilance of traffic accidents in the country.

**Insurance coverage**

Almost all countries adopt the mandatory insurance for traffic accidents, even if insufficient to meet the needs of the injured person or his family’s – in the event of parent loss in the crash. Several social problems arise from lack of insurance coverage, an issue that deserves more attention from the countries.

**Care of victims.**

For appropriate care of victims, it is essential that routines and flows be defined – reference and counter-reference, mainly – among the several services, municipalities and states. Developing a whole humanized attention project implies promoting a national policy that will articulate those factors and integrate urgency pre-hospitalization care.

In Brazil, it has been approximately two years since the Mobile Urgency Care Service (SAMU) was established with vehicles equipped for fast, qualified pre-hospitalization care on the 192 telephone number.

**Effective interventions**

- expansion of safety belt use – the three-point belt is 45 to 55% effective in preventing fatal injuries – and of car seats for children;
- placing children in the back seat;
- motorcycle riders wearing crash helmets; and
- prohibition of cell phone use by drivers.

**The elderly**

- identification and assessment of factors that affect this age group and that only cause damage to themselves, not others;
- evaluation of the moment and of how the elderly should stop driving; and
- survey of medications taken by the elderly that can affect their safety while driving.

Among such interventions, we highlight the proposal of policies to reduce alcohol-induced damages, a topic to be addressed at a specific conference.
RECOMMENDATIONS  
(CONSTRUCTED IN THE WORK GROUPS)

Road safety public policies  
- Developing a national, regional and local plan involving different sectors.  
- Creating a strategic committee led by an institution and involving health, police, transit, education, legal medicine, tourism, environment and culture representatives, as well as representatives from the civil society (NGOs) and private enterprise.  
- Having mandatory development of a state and health policy as part of the government’s agenda  
- Seeking to ensure political will and authority engagement in order that actions become effective  
- Coordinating competencies and responsibilities  
- Coordinating competencies and responsibilities for the sector;  
- Giving priority to actions towards reducing traffic accidents with victims;  
- Defining specific policies regarding motorcycles; and  
- Developing actions aimed at pedestrian safety.

Resources  
- Proposing budget increase for accident prevention, care and rehabilitation of victims.

Information System  
- Integrating the health information systems for dialoguing to be possible and to improve information quality.  
- Using information as a subsidy for public injury prevention policies

Media  
- Involving the media in road safety projects

Study and Research  
- Giving support to local, regional and national studies and research  
- Sharing methodology.

Legislation  
- Sharing with other countries, adapt and fill in voids, strengthen actions of revision and compliance.

Civil Society  
- Working with the population – civil society  
- Strengthening, sustainability of organizations that work with governments

Transit System Workers  
- Strengthening and qualifying the transit system operators
International Cooperation

- Obtaining international cooperation for the plan and for the committees – what are the needs
- Working beyond national borders for productive collaboration – sharing information and successful experiences (for example: CDC/PAHO injury vigilance)
- Disseminating the lessons learned from failures
- Adapting experiences to differences among countries.

Improving pre-hospitalization assistance and the care of traffic accident victims:

- Creating a system of emergency care
- Standardizing norms and routines
- Ensuring citizen participation (understood as the citizen knowing the emergency number to be called, etc.)
- Providing human resources with educational and qualification, establishing several levels of competence, certification and auditing.
- Setting up an urgency regulating center
- Making a 3-digit, toll-free and well-known phone number available
- Establishing norms for aerial, terrestrial and water services according to the level of service rendered (urgency, mobile intensive care units, transfers).
- Establishing a good communications system (radio, etc.)
- Assessing the system (one suggestion is to evaluate the response time and mortality)
- Establishing accreditation, certification and auditing processes

Alcohol Public Policies:

- Ensuring that policies that diminish consumption of alcohol will bear effect on alcohol and traffic accidents
- Enforcing the law, define a minimum limit for alcoholemia
- Providing education to the public in support of legislation changes
- Implementing more effective policies in the Latin America countries. PAHO develops a regional strategy.
- Training health professionals on the consumption public health perspective
- Stimulating research on alcohol and accidents
- Developing and using alcohol consumption indicators.

FINAL COMMENTS

Coordinated by the Pan-American Health Organization/World Health Organization, this meeting meant a significant step towards consolidating the role of the Health Sector in reducing deaths and injuries caused by traffic, as well as in the development of a pan-American road safety network which will give continuity to the exchange of experiences and their evaluation among the countries involved.

NEXT STEPS

Development of a Pan-American Road Safety Network to:
- disseminate information on the road safety indicators among countries, by way of the PAHO site, in English, Spanish and Portuguese;
- stimulate countries to develop a data bank on the topic for the sectors of Health, Transit, Transportation and Justice;
- share successful experiences;
- develop joint actions among countries to carry out the Road Safety World Week, to occur in April, 2007. Aimed at preventing accidents among the young, this Week is a recommendation of the Resolution on Road Safety, approved by the United Nations General Assembly in October, 2005.

Other theme areas to be addressed:
- factors that may either cause or prevent accidents – urban planning of the roads and of the transportation;
- protecting factors, or not – helmets, safety belts, children’s car seats; sheltered cars – airbag, vehicle safety;
- legislation – progressive licensing, restriction to alcohol drinking;
- evaluation of traffic accident prevention experiences; and
- handbook for orientation of studies on traffic accident costs.

Who would participate in the network?
- representatives from the Ministries of Health and Transit/Transportation of the PAHO member-countries;
- related non-governmental organizations;
- the private sector; and
- assistants to PAHO representations.
### Participants

<table>
<thead>
<tr>
<th>City/Country</th>
<th>Name</th>
<th>INSTITUTION</th>
<th>Cargo</th>
<th>Telefones</th>
<th>E-mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>Guadalupe Gallardo</td>
<td>Ministerio de Salud</td>
<td>Programas Médicos Comunitarios</td>
<td>5433-9840</td>
<td></td>
</tr>
<tr>
<td>Argentina</td>
<td>Eduardo Bertotti</td>
<td>Instituto de Seguridad y Educación Vial (INEV)</td>
<td>Director</td>
<td>54 11 4361-4818</td>
<td></td>
</tr>
<tr>
<td>Bolivia</td>
<td>Euloge Andrade</td>
<td>Policía Nacional</td>
<td>Director de Departamento de Atención de Situación de Salud</td>
<td>021 2 272-2684</td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Otávio Lázaro Morais Neto</td>
<td>Ministério da Saúde</td>
<td>Diretor do Departamento de Análise de Situação de Saúde</td>
<td>(61) 3315-3819</td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Eugénia M. S. Rodrigues</td>
<td>OPAS/OMS</td>
<td>Assistente Regional em Segurança no Trânsito</td>
<td>(11) 3426-9533</td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Cristiano Linsch</td>
<td>Consultor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Alicia Santiago</td>
<td>Detran/AL</td>
<td>Chefe de Estatísticas</td>
<td>82 7111-2243</td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Luiz Otavio M. Miranda</td>
<td>Mettla PA</td>
<td>Professor</td>
<td>(91) 3214-6335</td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Fabio Fernandes</td>
<td>Estaes/PAPA</td>
<td>Tecnico</td>
<td>(11) 9810-1504</td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Guilherme Ribeiro</td>
<td>FTA Foundation</td>
<td>Co-organizador</td>
<td>11 3811-5853</td>
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</tr>
<tr>
<td>Brasil</td>
<td>Maria Vintra de Morais</td>
<td>Secretaria Municipal Teresina</td>
<td>Gerente</td>
<td>66 3215-7731</td>
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<tr>
<td>Brasil</td>
<td>Victor Passarino</td>
<td>Consultor</td>
<td>Consultor</td>
<td>61 7344-2226</td>
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<tr>
<td>Brasil</td>
<td>Júlio Müller</td>
<td>Assessor</td>
<td>CONASS</td>
<td>61 3111-5206</td>
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<tr>
<td>Brasil</td>
<td>Filomena Marinho</td>
<td>SUS/Ministério da Saúde</td>
<td>Coordenador</td>
<td>61 3111-5101</td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Carlos Felipe</td>
<td>Secretaria de Assistência à Saúde/Ministério da Saúde</td>
<td>Chefe de Gerência</td>
<td>61 3111-5226</td>
<td></td>
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<tr>
<td>Brasil</td>
<td>Sônia R. Haddad</td>
<td>MPOG</td>
<td>Assessor</td>
<td>61 7111-5063</td>
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<tr>
<td>Brasil</td>
<td>Bernardes Sérgio Néglia</td>
<td>FTMU, Vida Urgente</td>
<td>(51) 9121-3345</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Silvana Costa Caetano</td>
<td>Secretaria Municipal de Saúde/Prefeitura da Cidade do Rio de Janeiro</td>
<td>(21) 2503-2259</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Ana Maria B. Simplicio</td>
<td>Secretaria Municipal de Saúde/Prefeitura da Cidade do Rio de Janeiro</td>
<td>(21) 2503-2247</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Edmilton Ramos de Souza</td>
<td>Centro ENH/Unicrac</td>
<td>(21) 2200-4913</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Adriana Maria Brito de Jesus</td>
<td>Secretaria Municipal de Saúde/Prefeitura Municipal do Salvador</td>
<td>(71) 3611-1042</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Salomão Kubnowitch Capuá Avitran</td>
<td>Psicólogo, Diretor, Presidente</td>
<td>(11) 3057-0244</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Mónica Edmundo Suelde</td>
<td>Oficial</td>
<td>(11) 3599-3500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Philip Gold</td>
<td>Grel Projects</td>
<td>(11) 3831-2935</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Lucena O. Reddy</td>
<td>Coordenadora</td>
<td>(11) 5373-3381</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Raquelte Ribeande</td>
<td>Dir. ARA Cerrado</td>
<td>(11) 8314-9174</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Vilma Poliena</td>
<td>secretaria do Estado de Saúde/Gov. do Estado de São Paulo</td>
<td>(11) 9362-9431</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Masa Helena F. Mello Jorge</td>
<td>Universidade de São Paulo, Professor F.S.P.</td>
<td>(11) 3066-7524</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Millen Steinman</td>
<td>Sociedade Brasileira de Atendimento a Traumatizados</td>
<td>(11) 9052-1502</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brasil</td>
<td>Andréa Nascimento</td>
<td>Conselho Federal de Psicologia</td>
<td>(27) 3243-3982</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chile</td>
<td>Jorge Rodriguez</td>
<td>Ministro de Salud de Chile, Encargado de Trauma</td>
<td>02 630-0931</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colômbia</td>
<td>Victoria Espina</td>
<td>CDC</td>
<td>370 490-4246</td>
<td></td>
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<tr>
<td>Costa R</td>
<td>Ray Rojas</td>
<td>COSEVI</td>
<td>3986-358108</td>
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</tr>
<tr>
<td>E.E.U.U.</td>
<td>Alberto Concha-Eastman</td>
<td>OPS/OMS</td>
<td>17 (202) 974-3980</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.E.U.U.</td>
<td>Mark Rosenberg</td>
<td>Global Road Safety Forum</td>
<td>904-687-3635</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.E.U.U.</td>
<td>Ismael Aroa</td>
<td>Director</td>
<td>70-488-4609</td>
<td></td>
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</tr>
<tr>
<td>E.E.U.U.</td>
<td>Arne Paulson</td>
<td>BID</td>
<td>2202-382-3028</td>
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<td>Country</td>
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<td>E.E.U.U.</td>
<td>Maricela Monteiro OPAS</td>
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