was important enough to warrant an exception. In part this was because it calls attention to the need for such a measure for children, and to the fact that to date, there have been few attempts to construct one. As is all too often the case, the needs of children lag behind those of adults. (It is analogous to pharmaceutical companies who first test a new drug on adults, where the market is larger, and only belatedly, if at all, do so for children.) The associate editors also advised that the paper be accompanied by an editorial commenting on where it fits in the array of measures in this domain. We welcome the guest editorial that follows, written by an internationally renowned expert in this field.

IB PLESS
Editor

Editor's note: the following is a statement reached by consensus of those attending the Third International Conference on Injury Prevention and Control in Melbourne. Readers are urged to publicize it widely in their own communities and work towards its full implementation.

The Melbourne Declaration

Injury is a threat to health in every country in the world and is currently responsible for 7% of world mortality. This proportion is predicted to rise. In high income countries, such as the United States of America, injury is the leading cause of premature death. In many low income countries, such as India, injury is the leading cause of death and morbidity in the middle of the age spectrum (from age 4 or 5 years to 35 years and older). Injury deaths and trauma can be significantly reduced through a strategic mix of education, environmental and design changes, community and organisation-based action, regulation and enforcement. Improved treatments and rehabilitation would also reduce the long term individual, social and economic burden of injury.

The international injury prevention community calls on global organisations, government and government agencies together with industrial, commercial, labour and other non-government organisations and the public that share responsibility for the SAFETY of the citizens of the world to work in partnership to:

- Allocate sufficient monetary and human resources to implement strategies to reduce injury rates from all causes in all settings
- Establish departments in all appropriate government ministries to provide the leadership, coordination and resources that are necessary to develop policies and programs which promote a culture of safety
- Provide resources to indigenous peoples to determine and implement programs to reduce the high incidence of injury among groups in their communities
- Involve government, trade, industry and labour in global action to reduce injuries that result from the manufacture and dumping of unsafe products and technologies, the manufacture of products in unsafe conditions and the exploitation of cheap and child labour
- Implement programs to reduce intentional injuries: suicide and attempted suicide, interpersonal violence and assaults with weapons, particularly guns and land mines

The international injury prevention community agrees to a worldwide partnership to act immediately on current knowledge to reduce injuries and the attendant social and economic costs by:

- Placing injury prevention and control higher on the agenda of the World Health Organisation, the World Health Assembly, the United Nations, and the World Bank and global trade, labour, consumer safety and transport forums
- Creating world networks and coalitions which bring together the professions, sectors and disciplines (and the technologies to support them) that enable cooperative action to reduce injury at the community, national, regional and international levels and the rapid transfer of data and information
- Securing a budget allocation for injury prevention and control from all governments
- Securing from trade, industry and labour the commitment and resources to create safer products and environments by technical solutions and organisational measures
- Establishing regional, national and international lead agencies and task forces with appropriate financial resources to coordinate and drive intersectoral injury prevention efforts
- Including the safety of the population in all strategic plans and operational activities at all levels in all organisations
- Improving the availability of accessible and linked data (which includes the cause of injury) and information on effective interventions, and increasing research which supports the design of new interventions

potentially amenable to specific types of interventions. For this purpose, the generic measure should be complemented by a disease specific or injury specific module as needed.

Would an SF-36 like instrument be enough to measure health in childhood, at least for now? I think not. In the case of young people, it is not enough to know their rates and causes of mortality, to know about their illnesses (whether acute or chronic), or to know their levels of disability and the states of their functioning. Young people are thought to be largely healthy and, by these adult standards of health, they are certainly more healthy than their elders. But there is another aspect of health that is more pertinent for children than for adults, and that is their resilience and vulnerability. A child or youth is not optimally healthy if he or she evinces characteristics that indicate a high likelihood of subsequent deterioration in health. Conversely, a resilient child — one who has resources that make him or her more resistant to the threats of deterioration — is healthier.

My colleagues and I have developed a 'long form' instrument for assessing health status of youth of ages 11–17 years. This instrument has been validated in several different populations; its properties have been published in the literature.[1] Our research group is actively working on several extensions of this work: a short version, a computerized version, and a version for children of aged 5–10. In contrast to existing instruments, the CHIP-AE® contains domains for resilience and vulnerability, as well as for disorders, discomforts, satisfaction with health, and achievement of social expectations. We are also nearing completion of work to develop specific profiles of health since there appear to be a limited number of patterns of scores across the six domains that can capture the full range of types of 'health' in adolescent populations. These profile descriptions should make our attempts at intervention much more informed and, thereby, more effective.

Thus, we have come a long way in the conceptualization of health and in its measurement. But our work will never be done. That which was once unfathomable becomes potential and then possible. Such is the challenge of our work.

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Reflecting reindeer

Jan Shield kindly sent the following clipping from *The Age*: 'About 70 000 Swedish reindeer have been fitted with reflectors to protect them from traffic accidents, with the resultant number of collisions down 27 per cent'. My reaction, If its good for reindeer, why not for children? Is there a mysterious message here?

Our values?

The revolver used by bandit Jesse James has been sold for $230 000 and a rifle presented to Teddy Roosevelt in 1909 was auctioned for $600 000, according to an editorial in the *Medical Post* (5 December 1995). A London gun expert says a good gun is a better investment than a good car, increasing in value by 20% in a few years. Still, gun owners object to the cost of a permit that would license their weapon. Funny old world!

More on guns

A study published in the December 1995 issue of *Archives of Pediatric and Adolescent Medicine* found that 25% of 3–4 year olds and 70% of 5–6 year olds had enough finger strength to fire nearly all of 64 handguns commonly sold in the US. A second study (in the same issue) reported that children who carry knives to elementary school to defend themselves or attack others are more likely to carry guns as high school students several years later (*Washington Post*, S Goodman).

Request for injury prevention in sports

Dr Caroline Finch has issued a request for literature on injury prevention strategies applicable to equestrian sports, skiing, snowboarding, cricket, softball, baseball, and soccer. She is particularly interested in formal evaluations of countermeasures. Contact: Caroline Finch, Monash University Accident Research Centre, Bldg 70, Wellington Road, Clayton, Victoria 3168, Australia.

Election of officers

The current composition of the ISCAIP Executive Board consists of three elected officers: President, Fred Rivara; Treasurer, Mike Hayes; and Secretary, Sue Gallagher, as well as up to five at-large members from Australia and New Zealand (Ian Scott), Europe (Wim Rogmans), Asia (vacant), Africa (vacant), and North/South America (vacant). The term of the currently elected ISCAIP officers expired on February 29th. A discussion of the election nomination process, the length of terms for office, the need for a chair-elect, and the need for more specific bylaws, ensued. Staggered, overlapping terms were proposed. There was also concern that we build in the capacity to maintain a relationship with the *BMJ*, our journal sponsor, and with CAPT, where our secretariat lies. A solicitation for nominations and revisited bylaws will be sent out shortly. Those with an e-mail address will receive it electronically; those without by regular post. This will be followed by a ballot to elect the board, which will, in turn, elect officers. A vote of confidence and thanks was given to our current President, Fred Rivara.

International conference in Amsterdam

We discussed getting involved early on with the planning of the Fourth International Conference on Injury Prevention and Control to be held in Amsterdam in May 1998. In the interests of promoting cross fertilization, the Australian conference did not have an age group orientation. Childhood injury prevention was interspersed among a variety of sessions. To ensure that sessions of relevance to ISCAIP members are planned, Mike Hayes will keep in touch with Wim Rogmans concerning the Amsterdam conference. Our goals are to have a major plenary on childhood injury, to group other childhood sessions, and to have a separate ISCAIP meeting.

Other

The need for developing consensus recommendations in areas such as the definition of pediatric injury severity was suggested as a future activity. Another issue was how to gain greater visibility and be accepted as a resource for global injury control activities so that, for example, WHO and others will seek our input. Special thanks were expressed to Ian Scott for making the arrangements for 65 of us to dine together after the business meeting.

SUSAN SCAVO GALLAGHER
Secretary, ISCAIP

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Where do the guns come from?

The tragic mass killing of 16 children in Dunblane, Scotland in March once again focuses the spotlight on the part played by the availability of guns. Although many argue that disturbed persons will always be a threat, others counter that this is precisely the reason why restricting the availability of weapons is so important. Our deepest sympathies go to the families, their friends, and the entire community.

New AAAM President from France

For the second time in its 40 year history, the American Association for Automotive Medicine (AAAM) has elected a non-American to be its president — Dr D Cesari, head of the Crash Protection and Biomechanics Laboratory in Lyon, France. The laboratory is a research unit of INRETS (the French National Institute for Research in Transport Safety).

Support for red light cameras

On average, at least in one US community studied, there is a red light violation every 12 minutes, amounting to an average of 126 per day. Encouragingly, two new surveys by the Insurance Institute for Highway Safety reveal that 66% favor using red light cameras that automatically photograph the rear license plates of vehicles that run red lights to help reduce this problem. Added to the basic problem is that violaters tend to do so at speed: 16% were going 55 mph or faster in a 45 mph zone.

playground.[10] In contrast, we found that only 40% of all injuries happened outside and only 27% were in a playground. This lower proportion of outdoor and playground injuries might be due to chance, but it also may reflect less use of outdoor locations during inclement Northwest weather. Indoor play areas and outdoor playgrounds together accounted for 84% of the injuries with a known location in this study; the remaining injuries were either in a dining area or other outdoor locations.

An analysis of playground injuries in Atlanta day care centers revealed that centers with a greater number of playground hazards were more likely to report a medically attended injury.[18] The Atlanta authors also found that taller climbing equipment was associated with fall injuries. These estimates were not adjusted for hours of exposure to day care.

We found little evidence that the number of potential hazards identified by an inspection at the start of the study had any relationship to the risk of injury. While a larger study with more injuries might have more power to evaluate the risk associated with physical hazards, most day care injuries may have little relationship to these potential hazards. We identified only two injuries that might have been due to a physical hazard, whereas most injuries were either due to falls at ground level or collisions with other children and with ordinary furniture. Other studies suggest that day care is relatively safe compared with the home,[8-10 12] and the injury rate estimated in our data is consistent with that conclusion. In addition, we found no evidence that the risk of injury differed between day care homes and larger day care centers.

The published studies suggest to us that the day care environment is relatively safe for children and current regulations regarding day care safety may be adequate. Large reductions in serious childhood injuries are unlikely to result from further regulation of day care. Furthermore, surveillance of day care injuries is difficult and time consuming and may not be worth the effort.

This work was supported by grants (U50/CCU007160 and R49/CCR002570) from the Centers for Disease Control and Prevention.

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US Congress kills national speed limits

As noted elsewhere, a new act repealing the maximum national speed limit in the US is likely to lead to 'an immediate jump in both travel speeds and crash deaths'. This is what happened in 1987 when states were permitted to raise speed limits on ural interste highways to 65 mph.

. . . And motorcycle helmet use laws??

The laws may also be at risk from the same legislation by permitting states to repeal or weaken existing laws in response to congressional abandonment of federal incentives.

. . . But the good news is less DWI??

The new highway safety law creates an incentive for states to combat alcohol impaired driving among underage drinkers by insisting on 'zero tolerance', under penalty of losing 5 to 10% of their federal highway funds (*Status Report* 1996; **31:** 1).

We emphasise that our findings raise socioeconomic issues that require political solutions at both national and community levels. We also contend, however, that it remains necessary to identify those areas in which individual behaviour is a significant factor and continue to address these concerns by educational preventative strategies.

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Child dies buried under snowman

A report from Zurich that appeared in the *Cape Times* (4 January 1996) describes the death of a toddler who suffocated after her father accidently buried her in a snowman. 'My husband didn't see her when he was rolling the snowball to make the snowman', said the mother, who assumed the child fell asleep on the ground.

Elmer's school safety game

For National Safe School week last year (1995) the Canada Safety Council produced a safety game — using a die with coins or buttons for markers, and you move around the board and you must 'remember to follow the rules along the path to get through safely'. (*Editor's note*: I have some questions: is there any reason to think that a single child played this game? If so, is there any reason to believe that it improved safety awareness, let alone practises? As if this were not enough, what in the world does a square 'You picked up after yourself in the classroom: advance 2 spaces' have to do with safety? Why is it 'rewarded' to the same degree as 'You always wear a helmet when you ride your bike'.)

Police cannot run red lights

After a child was killed by a police car in Montreal in 1990, the police were ordered to stop for traffic lights. Despite this, three women were seriously injured recently when a cruiser slammed into their car, apparently speeding through a traffic signal.

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Editorial Board Member: brief biography

TERRY NOLAN

Terry Nolan is an Associate Professor of Paediatrics at the University of Melbourne and a paediatrician at the Royal Children's Hospital. There, he is head of the Clinical Epidemiology and Biostatistics Unit. His medical degrees are from the University of Western Australia, and his PhD in Epidemiology and Biostatistics was completed at McGill University in Montreal in 1986. He is a Fellow at the Royal Australasian College of Physicians and a Fellow of the Faculty of Public Health Medicine in that college.

He established the Victorian Injury Surveillance System in 1988. More recently, he has helped establish the Victorian Emergency Department Minimum Dataset (VEMD), which is a model for emergency department based injury surveillance embedded in routine emergency department electronic data collection systems.

In addition to research arising out of child injury surveillance and the development of surveillance systems, he has been involved in a number of projects including community interventions to reduce injury in family day care, research on sporting injuries in children and adolescents, studies related to the prevention of bicycle injuries, and asphyxiation and burn injuries in children.

Dr Nolan was Chairman of the Scientific Program Committee for the recently completed Third International Conference on Injury Prevention and Control held in Melbourne.

designed and investigated to further increase helmet wearing rates, even after helmet wearing rates have increased and legislation has been implemented. This is particularly important for teenage bicyclists.

Future education programs should emphasise that helmets should be worn whenever a bicycle is ridden, not just in traffic or other obviously dangerous situations. Parents should also continue to encourage their teenagers to wear bicycle helmets. Education programs aimed at adults' awareness of bicycle safety issues could also be promoted to increase the number of parents who demand helmets be worn by their children and provide role models for teenagers. Given that changing behaviours in teenagers is difficult, the best long term solution would be to target education at young children to adopt a life long habit of helmet use, before they become teenagers.

Helmet manufacturers and government bodies could help by promoting the availability of modern, light, well ventilated, and stylish helmets. Teenagers are more likely to be happy about wearing such helmets and their availability would help parents encourage helmet wearing by their children.

Finally, this study has also raised enforcement as a factor in helmet wearing behaviours under a legislative system, even in a community with a relatively moderate level of enforcement. Only 15% of teenagers cited the possibility of receiving a fine or enforcement of the mandatory helmet wearing law by the police as a reason for wearing a bicycle helmet. This suggests that teenagers do not consider the issuing of a fine or police enforcement as either likely or serious. The possibility of a fine being imposed on non-helmet wearing bicyclists should be emphasised and enforced by the relevant authorities. The perception that fines are low and unlikely to be incurred should also be addressed.

Dr Caroline Finch was partially funded by a PHRDC (Public Health Research and Development Committee) Research Fellowship. The survey was administered and coordinated by third year health promotion students (Jason Ferla, Georgina Chin, Patrick Maloney, Pooma Abeysiri) as a research project for their course, supervised by Dr Finch. Analysis of the survey data was funded by VIC ROADS. The 14 schools, their students, and staff are gratefully thanked for their participation in the study.

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Choosing safe child care

Recently a coroner's inquest was held into the death of a 13 month old who was in the care of a homecare provider. She had been put down for a nap in a playpen in a closed room without a monitor and strangled on a broken hinge on the outside of the playpen while attempting to climb out. One of the coroner's jury recommendations was that 'Above all, parent awareness is the most important deciding factor when choosing a caregiver. The availability of this information should be a major priority'. But what safety issues do our readers think parents should look for when choosing child care?

using the model which fits the data (rather than using standard errors calculated from a model that doesn't fit the data), we too are unable to show that the difference of slopes is significant at the 'magic' 0·05 level. Thus, even though we agree with translating betas (and differences of betas) into numbers of injuries, we wonder if these numbers shouldn't be taken with a grain of salt. After all, from our conclusion that the difference in betas isn't statistically significant at the 0·05 level, we can project that the 95% CI for the number of injuries prevented will include zero.

The paper from New Zealand argues that a Gaussian distribution may not be appropriate, whereas a Poisson one would. In fact, the two are not mutually exclusive. If one had a Poisson distribution with a mean of 33 or 50 events per year (or >80 if we combine the two genders), then the distribution is also, for all intents and purposes, Gaussian. The main point of a Poisson distribution is that it is a one parameter distribution in which the variance equals the mean — something that appears not to be the case with the data in this application.

A cautionary note: if we fuss too much about the distinctions between these two forms of error variation, or between linear and log linear regression, or indeed other issues in modelling, we run the risk of concentrating too much on the 'small picture'. A much bigger uncertainty in the inferences we can draw from this study stems from the ecologic nature of the data and the fact that it is an 'unrandomized' study of $n = 2$ units (areas), each of which is subject to many other influences beyond those allowed for, or allowable for, in the analysis. So we should keep these arguments about models and p values in perspective: the results in the county as a whole are another sobering reminder of what else might be going on that our 'model' cannot account for.

In summary, the New Zealand authors appear to squeeze too much 'statistical significance' from the data by using a model that artificially makes the standard errors too small and the p values too extreme. The original authors could have used the data to their full advantage. However, if they *had* tried harder (as we did), by analyzing all of the 36 data points at once, the result would have remained 'NS'. But even if they had found $p = 0{\cdot}04$ rather than the 0·12 or some other such value, we would still need to be cautious in our interpretation.

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Believe it or not but this really happened . . .

A CCSN BBS correspondent writes: 'Because I am an in-line instructor who is very concerned with the issue of safety I tend to find myself in these situations. I was skating at an indoor rink when I saw this father readying his young daughter for skating. She was wearing all of the protective gear, a rarity for most indoor establishments. When I noticed them Dad was trying to put a helmet on the little girl's head. Part of the difficulty he was having stemmed from the fact that the helmet was backwards.

You've really got to learn the correct way to wear a helmet, and because it's not apparent to everybody, I always try to be helpful. I skated over to the father and told him that his daughters' helmet was on backwards. He told me that it was 'okay', I thought maybe he didn't hear me as the music sometimes gets quite loud. I tried again. I explained that the back of the helmet is the side with the most styrofoam, to cushion the base of the skull in a backwards fall. Dad thanked me very politely, and explained that it didn't matter, as his daughter was not capable of skating fast enough for it to be an issue. Well how do you argue with logic like that? Apparently he thought she'd be travelling fast enough to require a helmet, but not quite fast enough to require she wear it correctly.

Well Dad was right about one thing — the little girl didn't skate very fast — [and] the other kids were darting about her like 'bats out of Hell'.

Every now and then one of those kids would get a little too close and that little girl would be on the ground. It didn't take long for the helmet to slip off her head and dangle about her neck like the Red Baron's scarf. I watched Dad race out and reaffix the still backwards helmet several times. I tried to explain to him that helmets are designed to fit the head a specific way, and that maybe it would stay on better if he turned it around. He felt her hair was making it slip off and again he would be more concerned about it being on correctly if she could skate faster. (There was that wacky logic again.)

After about the ninth attempt to reaffix the helmet Dad decided to try turning the helmet the other way. After she skated the two laps without incident he announced that maybe it did fit better when it was on correctly' (CCSN BBS).

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Editorial Board Member: brief biography

LIZ TOWNER

Liz Towner graduated with a BSc in geography from the University of Durham, UK in 1972 and obtained an MA in geography from York University, Canada in 1974. After teaching in a range of secondary schools she started working in dental health education research in the Department of Dental Health, University of Birmingham in 1980. This involved developing and evaluating dental health education programmes in school and workplace settings, which formed the basis for a PhD in 1986.

Since 1990 she has worked in childhood injury prevention research in the Department of Child Health, University of Newcastle upon Tyne. She was appointed as Senior Lecturer in Health Promotion and Executive Director of the Childhood Injury Prevention and Promotion of Safety (CHIPPS) Programme. The programme is funded by the Department of Health and Northern and Yorkshire Regional Health Authority. The focus of the research programme is on children, unintentional injury at a local and regional level, and the effects of social deprivation.

Liz Towner's research interests are measuring the prevalence of exposure to injury risk and the application of risk data in local injury prevention, effectiveness reviews in injury prevention, and evaluation of injury prevention programmes.

and to adjust our existing measures accordingly. It will also provide us with estimates of children's exposure at junctions and near stationary vehicles which can be related to the relevant accident statistics to provide measures of risk in these situations. In the same way that our initial estimates of risk enable comparison to be made of the behaviour of differentially risk groups of children, so such new estimates could be used to compare the behaviour of children in situations of differing risk.

This work was supported by a grant from the Department of the Environment's Transport and Road Research Laboratory, Crowthorne, Berkshire, England, as part of the research programme on road safety. National accident statistics were provided by their Accident Analysis Division.

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Hazard of latex balloons

Readers were alerted previously to this hazard. A report in *JAMA* (13 December 1995) notes that balloons cause 29% of 449 deaths in children due to aspirating foreign bodies reported to the Consumer Product and Safety Commission (US) between 1972 and 1992.

Carbon monoxide detector works

A family in Owen Sound (Canada) survived a carbon monoxide level 400 times above the allowable amount from a leaking hot water tank, thanks to a carbon monoxide detector they had installed days previously. These devices are contentious: readers who know whether they really work or not are encouraged to share their knowledge with others through this journal. A similar episode is described in the winter issue of *Campaign Update* from the National SAFE KIDS Campaign (US).

Res ipsa loquitor

Local residents who have tried to convince the authorities to install a speed bump on a dangerous corner 'where drivers consistently ignore the stop signs' received the following reply from the police: 'Speed bumps cost $3000 to install and remove'. A city councillor added that they 'were a pain, because they have to be removed every winter'. A spokesperson for the parents replied 'What's more of a pain — removing a speed bump, or dealing with an serious injury' (*Gazette*, 29 November 1995).

Helmet law controversy: chapter XXX

Three municipalities in the Montreal area have now introduced helmet laws. The provincial minister still refuses because 'it would be difficult to enforce'. An interesting twist to the controversy is the fear that 'If you have a bylaw and don't enforce it and something happens, we've been told that legally (the victim) could sue us', explained a public safety inspector. (*Editor's note*: would that it were so!) And a typical response from a cycling refusenik: 'Helmets give cyclists false sense of safety and perhaps encourage daredevil-type behavior. I see people wearing helmets who do things I wouldn't do — darting in and out of traffic'. (*Editor's note*: worth studying?)

safe. Implementation of the plan's recommendations requires the ongoing 'buy in' of those organisations involved in its development.

SAFE ROUTES TO SCHOOL PILOT

As part of a special commitment to child pedestrian injury prevention, Safekids is currently undertaking a major pilot of the Australian (Vic Roads) *Safe Routes to School* programme. The programme involves developing an intersectoral approach to reducing school journey injuries among children in high risk communities. It emphasises the importance of creating safer roading environments alongside the education of children, caregivers and communities, enforcement, and the creation of safer school policies.

KIDSAFE WEEK 96

During 1996, Safekids is facilitating and coordinating the development of *Kidsafe Week 96*, New Zealand's first child safety week, which will be held in September. The week is a collaborative venture involving a number of national organisations involved in road safety, injury prevention, fire safety, and child health. The week's founding sponsor is Panadol.

Kidsafe Week 96 will raise awareness of unintentional child injury and, again, the need for safer road, home, and play environments. It will also provide a focal point for prevention around selected mechanisms of injury under each of these environments — children playing with lighters/matches and hot household water scalds (for the home environment), injuries to pedestrians (the road environment) and trampoline related injuries (for the play environment).

The week will include three tiers of activity — national awareness raising through the media, community based action through local coalitions being developed for the week, and advocacy with key decision makers around selected key issues.

Conclusion — moving funders beyond 'one issue' thinking

At Safekids one of our ongoing advocacy and awareness challenges lies with those who can provide the funding necessary for our work. In particular, those funders who may underestimate the complexity — not only of working in prevention — but also of the field of unintentional childhood injury itself.

A New Zealand colleague compares working in child injury control to working to control infectious diseases. We can 'immunise' children against serious injury in a car crash through the use of a proper child restraint. But that particular form of 'immunisation' is no more effective in preventing bicycle head injuries or hot water scalds than a vaccine for measles would be against whooping cough or AIDS.

Child safety is not about 'one size fits all' solutions, nor are organisations that work to prevent childhood injury, 'one issue' organisations. Childhood injury prevention is a complex and challenging field requiring a skilled, flexible workforce able to quickly come to terms with multiple injury areas — each with their own set of causal factors; their own set of communities, organisations, and decision makers who need to be involved in developing solutions; their own processes; and their own attitudinal, practical, design, and political challenges.

Effectively getting this message across to hoped for funders is probably the biggest ongoing challenge Safekids — and we suspect all of us working in child injury prevention — face.

For more information on Safekids write to Reena Kokotailo, Director, or Mary Parkinson, Information and Resource Centre Manager at the address shown on p 162. (telephone: +64 9 307 8965; fax: +64 9 307 8965; Internet: safekids@iconz.co.nz).

Think First revisited

Despite the pessimistic appraisal of this programme published in a previous issue of *Injury Prevention*, the newsletter of Think First Canada attributes the decline of catastrophic brain and spinal cord injuries in Nova Scotia, between 1991 and 1994, from 32 to nine, to this programme. (*Editor's note*: in view of the concerns expressed by the Seattle group, this widely publicized programme is urged to further assess its effectiveness. I was astounded to see in the newsletter an unequivocal endorsement by the Director of the Montreal Neurological Institute. I can only assume that he had not read the paper in question.)

More on tertiary prevention: three is better than two

A report from the Agency for Health Care Policy and Research by Kellerman shows 'that three firefighters can perform CPR more effectively than two, when they use a bag-valve-mask (BVM) device. The three rescuer technique overcomes the problem of providing unassisted ventilation with BVM.

is a step by step manual of seven curriculum modules designed for the classroom teacher. The modules on self esteem and assertiveness use open ended questions to generate discussion. The unit on 'coping with hazards' promotes taking children on a tour of their classroom and building to understand potentially dangerous areas, including a brief discussion of physical injury risks from electrical and poisonous sources, in addition to teaching children about using a telephone in case of an emergency. 'It's my body' uses pictures to teach about body parts and anatomical names, followed by a fifth module to discuss the idea that certain body parts are 'private areas'. The final two units relate to discussion of 'feelings' and 'touching' using pictures, worksheets, and discussion.

Classroom teachers, parents of children with disabilities, social workers, and clinicians involved in child protective services will find this book quite useful as they will have some concrete ways of approaching this difficult topic. Since the text is rooted in an educational perspective, it will be useful for working with individual children or classrooms. Population based policy matters are not discussed in depth. In addition, this text is *not* an exploration of prevention of other forms of injury such as those caused by motor vehicles, pedestrian collisions, or firearms for children with disabilities, as the title might at first imply. Thus, it will not be of widespread interest to most childhood injury prevention professionals. A book about general injury prevention for children with disabilities is badly needed and would be most useful to practitioners and policy makers.

RAVI RAO
Johns Hopkins University, Baltimore, USA

CALENDAR AND NOTICES

Forthcoming events

Working with a net
A national conference to foster relationship and collaborative efforts in injury prevention will be hosted by the Centre for Injury Prevention and Research–KFL&A/Queen's Teaching Health Unit, Kingston, Ontario, Canada. It will take place 12–15 June 1996 in Kingston, Ontario. Further details: Valerie Stenzel, Injury Prevention Officer, CIPR, 221 Portsmouth Avenue, Kingston, ON K7M 1V5.

World Congress '96: The Human Right for Safety
The 7th World Congress and Exhibition, 'Preventex '96', will be held 17–19 June 1996 in Budapest. It is sponsored by the National Commission for the Prevention of Accidents.

ISPCAN 11th International Congress
This meeting of the International Society for the Prevention of Child Abuse and Neglect will take place in Dublin, Ireland, 18–21 August 1996. Further details: ISPCAN Eleventh International Congress, Clifton House, Fitzwilliam Street Lower, Dublin 2, Ireland.

1996 International IRCOBI Conference on The Biomechanics of Impact
This conference will be held in Dublin, Ireland, 11–13 September 1996. Further details: IRCOBI Secretariat, INRETS, 109, Ave Salvador Allende, 69500 Bron, France.

AAAM 40th Annual Conference
The 40th annual conference of the American Association for the Advancement of Automotive Medicine will be held 7–9 October 1996 in Vancouver, British Columbia, Canada. Further details: AAAM Headquarters, fax: +1 708 390 9962.

Australian Playground Safety Conference
The NSW Playground Safety Network is organizing this conference, which will be held in Sydney, Australia, 28–29 October 1996. Further details: Anne Warn, Health Promotion Unit, Central Coast Area Health Service, PO Box 361, Gosford, NSW 2250.

Pre-Congress Workshop, International Congress of Pediatrics
There will be a Pre-Congress Workshop, Injuries: Intentional and Unintentional, at the Ninth Asian Congress of Pediatrics to be held in Hong Kong in March 1997. Further details: Michael Gracey, MD, PhD, Principal Medical Adviser, Aboriginal Health Division, Health Western Australia, PO Box 8172, Stirling Street, Perth, WA 6849, Australia.

Injury Epidemiology and Injury Control
An intensive five week program into the management of safety promotion and injury control will be held in spring 1997 in the Netherlands, organized by the WHO Collaborating Centres on Safety Promotion and Injury Control in cooperation with the Netherlands Institute for Health Sciences and the Netherlands School of Public Health. Further details: NIHES, Erasmus University Medical School, Hoboken, Room Ee 2185, PO Box 1738, 3000 DR Rotterdam, The Netherlands.

The 4th World Conference on Injury Prevention and Control
Wim Rogmans, Chairman of the National Steering Committee has issued the formal invitation to the next world conference, to be held in Amsterdam in 1998. Start saving! Further details: Conference Secretariat Injury Prevention and Control, PO Box 1558, 6501 BN Nijmegen, The Netherlands.

MORE WEB SITES

InterNet Health Resources
http://www.arcade.uiowa.edu/hardin-www/md.html

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MedWeb:Public Health
http://www.cc.emory.edu/WHSCL/medweb.ph.html

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The Global Health Network
http://www.pitt.edu/HOME/GHNet/GHNet.html

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The World-Wide Web Virtual Library: Epidemiology
http://www.epibiostat.ucsf.edu/epidem/epidem.html

*

Canadian Society for International Health
http://hpbl.hwc.ca:8500/

*

The Children's Safety Network (CSN) National Injury and Violence Prevention Resource Center at Education Development Center (EDC)
http://www.edc.org/HHD/csn

*

Building Bridges Between Traffic Safety and Public Health
http://www.edc.org/HHD/csn/buildbridges

*

NHTSA home page
http://www.nhtsa.dot.gov/>

InjuryNet (Harborview IPRC) electronic mailing list (aka a 'listserv') is available by sending an e-mail message to listproc@u.washington.edu saying subscribe injurynet (firstname lastname).

Computer program review
Not a site (I don't know where else to put it) but another sign of the technologic times is the excellent computer program *Kids & Guns*. This computer presentation is from the Program Against Violent Events (PAVE), which originates in the Violent Injury Prevention Center at Children's Memorial Hospital in Chicago. The focus of the center is the prevention of firearm injuries and child abuse. Katherine Kaufer Christoffel is the principal investigator and the computer program was supported by NHTSA and MCHB through an Emergency Medical Services for Children grant.

Kids & Guns is easily installed on Windows or Win95 and includes excellent graphics, statistics, a speech (that can be modified), references to important articles, and information about other organizations. Do try it! I am certain you will be impressed.

Notice to contributors

Injury Prevention will soon be eligible for inclusion in *Index Medicus*. Contributors who may be deterred by the journal's present 'non-indexed' status are reminded that once approval is given, all published peer reviewed papers in back issues will be indexed retroactively.

JOURNAL CITATIONS

Editors note: these citations have been culled from the following databases — Medline, Current Contents, Psych Abstracts, and Social Science Citation Index. Your comments are welcome, as well as suggestions about other pertinent databases.

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about their children's safety (Journal of Public Health Medicine *1994;* **16:** *439–46).*

French researchers conducted a one year prospective study of 937 childhood burns presenting to 14 burn centres and 18 paediatric surgery units throughout France (*Burns* 1996; **22:** 29–34). Toddlers aged 1 to 3 years were most affected. More than half the burns occurred in the kitchen, often while mothers were present, but the more serious burns happened in the bathroom. While most burns were small and superficial, one third were serious enough to require skin grafting. Older children were commonly burned by the ignition of volatile substances; flame burns caused seven of the 11 deaths. There are no mandatory burn protection regulations in France, and the authors commend a range of environmental approaches (antiscald devices and 'cool' oven doors) as well as tackling burns' prevention at the level of the European Union.

The principal recommendations of a review commissioned by the Australian government into countermeasures to reduce drowning, near-drowning, and spinal injuries from diving into shallow water are the compilation of detailed national information about these events from coroners' files, the requirement for police investigating deaths to record details such as the presence or absence of pool fencing, the need for a study into adolescent drownings, advocacy for pool fencing, and requiring all pool owners to be trained in first aid (Review of countermeasures to reduce drowning, near-drowning and spinal injuries from diving into shallow water. *J Nixon,* et al. *Canberra: Department of Human Services and Health, 1995).*

JAN SHIELD
March 1996

Child poverty — league tables
Because of the close relationship between poverty and injuries, readers may be interested in *New and Issues*, Fall/Winter 1995, from the National Center for Children in Poverty (US). It includes a sobering, but perhaps not surprising graph, depicting the gap between poor and affluent children, by country. The largest gap is found in the United States, Canada, and Switzerland; the smallest, in Ireland and Finland.

Violence research gets a boost
The National Science Board has approved a plan to award $12.1 million to Carnegie Mellon University (US) to establish a National Consortium for Research on Violence. The aim is to 'generate fundamental knowledge about the causes and consequences of violence'. The plan is to assemble a team of 39 researchers from 24 institutions in 11 states, Canada, and four European countries.

Child resistant lighters?
Despite the fact that as of June 1995 all disposable lighters sold in Canada were required to be child resistant (by requiring two separate actions to make it work), while preparing this section I went to the corner store and inspected the lighters for sale. Although they met this standard it is hard to imagine any child having difficulty using them. To whom do I complain? I know, but does the average citizen?

Injury to children and teenagers: state-by-state mortality facts
This 76 page fact book by Susan Baker, Lois Fingerhut and others, has just been released. It is a goldmine of sobering information about injury deaths in the US, but will also be of value to researchers in other countries, both as an example of how such data can be presented, and for purposes of comparison. Three intriguing facts: the total rate for 0–19 year olds is 30 per 100 000 per year; Massachusetts showed the largest per cent decrease between 1980–5 and 1986–92 (−19%); and guess what the category was showing the greatest decrease? Farm machinery and motorcyling, −44% and −43%, respectively. But no surprises in the greatest increase: firearm homicide, 63%.

Mortality rate for children in farming accidents alarmingly high
The auditor for Ontario (Canada) suggests that prehospital care in that province is poor. An emergency care physician goes further, describing the service in rural areas as 'obscenely' poor. In support of his allegations, the physician states that 'your chances of dying in a rural road accident are seven times greater than in an urban setting, largely because of distance and time factors to emergency care'. He adds, 'The mortality rate for children in farming accidents is . . . about 30% of the death total'.