Southern Africa (and beyond) report

I am constantly aware that most of my reports selfishly concentrate on happenings in Southern Africa. Occasionally, I am able to glean the odd item on what is happening further north from news reports, what little there is on the internet—or from that outstanding monthly, “BBC Africa”. Rather than bore readers with poor excuses for this imbalance, may I rather reconfirm that I would welcome news (in any form whatsoever) related to childhood injury in Africa, and inclusion of which would allow this column to become more representative of the entire continent than it currently is. Those who are kind enough to submit news items will be person- acknowledged.

Having got that off my chest, I am thrilled to report on a fresh and exciting injury prevention campaign that has been hatched in Uganda, thanks to both support and input of the regional and national agencies who have been working with the Ministry of Health. I am extremely grateful to Dr Olive Kobusingye, Director of the Injury Control Centre based at Makerere Medical School in Kampala, for providing me with the following information:


The adoption of a standardized minimum data set for hospital based injury surveillance was discussed. A trauma registry form tested and used by the ICC-U will be presented to injury control workers in participating countries for the development of a common format; it is hoped that this data set will form the core of a common trauma registry system in these countries. The single page trauma registry form includes ICD-9 categories of injury, a severity instrument (the Kampa score), victim and event information, and in- tentionality. Operate definitions for the registry have been written, and the form has already been tested in Uganda and Ethiopia. The trauma registry form includes ICD-9 categories of injury, victim and event information, and intentionality. Operable definitions for the registry have o

The green papers are especially noteworthy in that the New Labour administration explicitly recognises the strong association between poverty and poor health and the need to tackle the former (as well as lifestyle and behaviour) in the context of a comprehensive health promotion strategy.

For England, 12 year targets will be set to reduce mortality and morbidity in four priority areas: heart disease and stroke, accidents, cancer, and mental health (suicide). Targets do not feature prominently (although they are not ruled out) in the Scottish paper which, in addition to the above four areas, flags up a number of others, particularly teenage pregnancy and dental health.

The green papers have been broadly welcomed by public health professionals. Disappointment has been expressed however on two main counts. First, no targets have been set to monitor progress towards reducing the widening socioeconomic inequalities in health in the UK. Second, the proposed action seems weak on specific, sustained, and adequately resourced measures designed to make a major impact on the underlying social, environmental, and cultural causes of ill health. Moreover, while the poorer health (including injury) record of the Scots is acknowledged, this is not backed up by a commitment to mount a proportionately more vigorous health improvement programme north of the border.

For injury prevention professionals, the statements are a mixed blessing. On the positive side, “accidents” have held their place as priority areas in both England and Scotland. Unfortunately, the writers of the green papers have clung to an outmoded and discredited terminology, have offered virtually no new ideas to address the injury problem, and have proposed targets that are likely to be met in the absence of any further policy initiatives whatsoever. Cynics might argue that therein lies the huge political appeal of the target setting exercise!-

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LETTERS TO THE EDITOR

Safety strategies

Editor,—Jan Shield is to be commended for rallying the troops in favour of “active” safety strategies, and most of her arguments in favour of education and enforcement would undoubtedly be valid in a developed country. However I would like to offer two contrasting viewpoints on the subject which are based primarily on personal observations related to the challenges of traffic safety confronting us in a cash strapped, developing country.

Firstly, in support of passive measures is the increasing strain placed on the human and financial resources essential to conceive and sustain education programmes and law enforcement, particularly in developing countries. As such, traffic calming measures are likely to be more effective than nothing—simply because there is no affordable solution to uncontrolled traffic flow on a
particular thoroughfare. Twelve months ago, the community in which I live opted for a system of restricted entry through the suburb to reduce to number of “rat runners” speeding along a particular route during the early morning. At the time the system was put in place, law enforcement of the system was sufficiently regular to be taken for granted, and to ensure an 86% reduction in traffic flow. Then, three months ago, the traffic department underwent severe rationalisation, and the law enforcement of the system was reduced to such a degree that it became effectively unenforced. Now there is no enforcement of the restricted entry system and the “rat runners” are back in force. In retrospect, a passive measure such as closure of the main access road would obviously have been the better choice. In South Africa, where formal education is limping along on a shoestring budget, and law enforcement (for a multitude of reasons) is virtually non-existent in some areas, the option of passive safety measures must be placed high on any agenda—not because traffic safety is concerned.

Against what I have argued above is a word of caution. Just as active measures may fail, so may the too hasty adoption and construction of passive measures which is inappropriate for the identified purpose. Possibly because environmental modification may be the quickest and cheapest solution to an injury hazard—a form of instant gratification—the device too hastily chosen may fail dismally to counter that hazard simply because of a lack of adequate research into the hazard itself, or failure to consult expert opinion before firing up the cement mixer. Again, in South Africa, I notice a growing trend for traffic calming measures to be demanded by community groups, often in response to a spat of casualities in a residential area, or because a particular intersection has been identified as a “black spot”. Lay people may go one step further and put pressure on a municipality to construct a specific kind of device, speed humps being particularly popular, although by no means a panacea where the hazard may be brought about by a complexity of factors of which vehicle speed is only one. Also, piecemeal engineering may simply divert a hazard elsewhere so that it becomes the problem of a neighbouring suburb instead.

The most effective passive strategies may simply be a sound planning decision rather than hoping vainly that a “finger in the dyke” approach will plug the gaps later on. Resorting to an ad hoc solution reflects that town planners eschewed safety considerations from the outset and the attitude that condones such blinkered thinking must be discouraged. There is currently a backlog of over two million subsidised houses in South Africa. These can be constructed either according to an inept and insecure plan which creates a host of accommodation, and many attendant hazards, or by careful planning that can ensure that safety features are built into the scheme as a whole, for example sufficient recreational space and play areas, shorter streets, restricted access for through traffic, etc. In that effective, enduring passive safety measures do indeed require foresight, research, and careful consideration, these should not be either rushed to or designated as a “cope out”, or even worse, as a quick fix.

**Challenge of drowning prevention in low and middle income countries**

**Editor,—**We read the editorial on “The challenge of drowning prevention” with great interest. There is no doubt that drowning is a major but under recognised cause of premature loss of life and disability. This has been borne out by the Global Burden of Disease Study which highlights the scale of the problem, by region and by age and sex characteristics. It is worth examining their findings further.

At a worldwide level, Murray and Lopez estimated that drowning was responsible for about half a million deaths in 1990 and 20th leading cause of mortality, after road traffic accidents (9th), self inflicted injuries (12th), and violence (17th) as the other injury related causes. Mortality rates from drowning were highest for children under 5 in China, followed by countries belonging to the “other Asia and islands region”, and sub-Saharan Africa, with the lowest rates in the “established market economies” (EME) 

In this age group, the mortality rate ratio between China and the EME was 13:1 in boys and 22:1 in girls.

The large degree of variation between the different regions in the study must belie an even greater variation both between and within countries, given the different geography and populations. There is great diversity in the circumstances in which drowning occurs in these different areas. Whereas swimming pools, sailing, and water sports may be priority areas in the EME, low income countries attention must need to be paid to drowning in streets, wells, dams, cisterns, and while fishing. Clearly there are a huge range of different environmental and behavioural circumstances. The obvious intervention to keep the child who cannot swim away from water must have a different interpretation in the different regions. Although swimming pools could be fenced in EM economies, the fencing of waterways would be impractical in countries where this runs into thousands of kilometres. This is not to say that there are no common approaches. As the editorial rightly points out, education about the risks, both through supervision, and training in resuscitation are important first steps which could be applied globally. Researchers also need to study the circumstances under which drowning occurs and the first aid and health care response, within countries and cross nationally. Data on good practice need to be collated so that appropriate interventions which are transferable to other low and middle income countries can be easily identified. Whatever the intervention there is an urgent need to get drowning higher on the agenda for policy makers and researchers.

*The Global Burden of Disease Study used the eight global regions identified by the World Bank for the World Development Report 1993 with similar levels of socioeconomic development, epidemiological homogeneity, and geographical contiguity: the EME, former socialist economies of Europe, India, China, other Asia and islands, sub-Saharan Africa, Latin America and the Caribbean, and the Middle East crescent (which includes North Africa, the Middle East, Pakistan, and the Central Asian republics of the former Soviet Union).*
Wilde is not arguing that people enjoy or seek risk of injury. Like behavioral decision analysts and economists, he postulates that people select or accept risk targets in order to achieve other desired ends in life. When safer highways are built, drivers trade some or all of the extra safety for faster travel speeds and more relaxation (and inattention) in driving. When road conditions deteriorate (due to ice or fog), people sense elevation in risk and respond by slowing down and driving with more caution. Usage variations on this adaptation theme, Wilde challenges the effectiveness of most mainstream injury prevention measures: seat belt laws, antilock brakes, traffic lights, driver training/education, crackdowns on drunk and driving, highway design improvements, motorcycle helmet laws, you name it! Even more provocatively, Wilde hints that any long term progress that might be made in safety could be offset by increases in the risk of fatal diseases (since people’s overall risk target is maintained).

Technical specialists will certainly find fault with Professor Wilde’s handling of a variety of empirical questions. For example, I thought his discussion of the association between the business cycle and injury frequencies was fair and insightful, yet his assessment of the effectiveness of safety belts was highly selective, one sided, and arguably deceptive. Professor Wilde also has a tendency to see risk homeostatic explanations behind all empirical anomalies. Again, on safety belt use laws, Wilde notes that if belts are 50% effective in saving lives, and if belt use rates increased 50 percentage points following laws, why didn’t laws cause an immediate 25% decline in occupant fatality counts? (Wilde is correct that few jurisdictions have experienced 25% reductions in fatalities after belt laws.) Ah, Wilde asserts, maybe drivers offset the benefit of the safety belts by taking more risks. Some alternative explanations that Wilde ignores are (a) that the law only applies to specific (for example, drunk and young males) may be least likely to comply with the law, (b) the 50% increase in use is an exaggeration, and even (c) the 50% effectiveness number may be biased upward (we thought belts might be 60–90% effective).

Yet I would urge specialists to overlook Wilde’s handling of detailed technical matters because such focus can cause the reader to shortchange Wilde’s overall message. It is a message that the field of injury prevention needs to hear. We spend remarkably little effort on bottom-up approaches to motivating safer behavior. Osias Baptista Neto (techtiran@ouro.alcance.com.br) reported that Brazil has reduced casualties dramatically after a change in traffic law at the beginning of the year. The new laws recognize that vehicular homicide may be unintentional but none the less results from risky behavior. Killing another person in a traffic crash results in imprisonment for two to four years, and a suspension or revocation of the driving license. It increases the penalty by half for striking a pedestrian in a crosswalk or on the sidewalk (pavement). He reports that preliminary data show a 70% drop in casualties in the major cities like Sao Paulo, Belo Horizonte, and Curitiba. His report illustrates the benefits of global comparisons of injury control efforts. He too connects the English speaking world, but extra effort is required to reach beyond the barrier of differing language. The barrier is especially significant with legal terms and concepts. However difficult to analyze, injury prevention specialists need to examine international differences in how legal systems treat motor vehicle injuries.

PEDNET

One of the strengths of the pedestrian e-mail network, PEDNET, is the diverse background of the participants. Last month, a physicist, Alan Streater (ads4@lehigh.edu), used his analytical skills to examine how major newspapers covered 42 motor vehicle pedestrian crashes. He termed his analysis “quick and dirty” but it provides insight into the quality of coverage. He categorized the wording in the reports into neutral, slightly biased against the pedestrian, or very biased against pedestrians (for example, “dared out”, “ran out into traffic”, etc). He found the wording was mostly neutral in 26 out of 42 (62%), partially biased in five cases (12%), and clearly biased in 10 cases (24%). In six cases (14%) the report provided additional wording to excuse the driver, such as “it was raining and hard to see”. There were no cases in which wording appeared to exonerate the pedestrian in any way. Alan had a disturbing observation—that newspaper reporters obtain their understanding of the fatality from police reports. He sees the need for a more careful analysis of biased language in newspaper coverage and, perhaps more importantly, police reports. The consequences of this bias may be more than just public perception; this bias may also jeopardize the prosecution of dangerous drivers. He also recommended comparing interregional and international differences in bias. He also reported the coverage of charges filed. A driver was reported to be charged in only one case out of 42 (2%). In all other cases (98%) the police apparently did not even issue a traffic ticket to the driver at the scene of the crash or shortly thereafter. In six cases, the crash was reported to be still undetected, implying there is still a chance that some of these drivers might be charged later. Two cases were hit and run, and in one case the driver died. This analysis closely matches Amy Lightstone’s recent analysis of driving analysis of drivers who kill child pedestrians. She found that 214 out of 237 drivers were not cited (90%). Can something be done to change this obviously dangerous situation?

Again, the diversity of PEDNET participants provides insight into addressing driver behavior. Osias Baptista Neto reported that Brazil has reduced casualties dramatically after a change in traffic law at the beginning of the year. The new laws recognize that vehicular homicide may be unintentional but none the less results from risky behavior. Killing another person in a traffic crash results in imprisonment for two to four years, and a suspension or revocation of the driving license. It increases the penalty by half for striking a pedestrian in a crosswalk or on the sidewalk (pavement). He reports that preliminary data show a 70% drop in casualties in the major cities like Sao Paulo, Belo Horizonte, and Curitiba. His report illustrates the benefits of global comparisons of injury control efforts. He too connects the English speaking world, but extra effort is required to reach beyond the barrier of differing language. The barrier is especially significant with legal terms and concepts. However difficult to analyze, injury prevention specialists need to examine international differences in how legal systems treat motor vehicle injuries.

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Correction
We regret that a production error occurred in the March issue; this resulted in three addresses being omitted. The missing addresses are as follows:

- Charles Larson (Going international: what are the implications? p 4), Pediatrics, Epidemiology and Biostatistics, Montreal Children’s Hospital, 2300 Tupper, Montreal, Quebec H3H 1P3, Canada.
- Robert W Platt (ANOWA, t tests, and linear regression, p 52), McGill University/Children’s Hospital, 2300 Tupper, Montreal, Quebec H3H 1P3, Canada.
- Chester S Jones (Children and personal watercraft: injury characteristics and potential countermeasures, p 61), Health Sciences, University of Arkansas, 308 HPER Building, Fayetteville, AR 72701, USA.

18–22 October 1998. Fourth International Symposium: Rural Health And Safety In A Changing World, Delta Bessborough Hotel, Saskatoon, Saskatchewan, Canada. Organized by the Centre for Agricultural Medicine, University of Saskatchewan in cooperation with the Canadian Coalition for Agricultural Safety and Rural Health, Committee on Occupational Health In Agriculture of the International Commission on Occupational Safety and Health, and others. This conference seeks to capture the emerging science of health, safety, and sustainability in agriculture and rural life, and to probe beyond these issues to address the thriving and survival issues of the future. In addition to abstracts from scientists, health care workers and others, abstracts are also invited from rural people with views on this topic. Further details: Fourth International Symposium: Rural Health And Safety In A Changing World, Centre for Agricultural Medicine, RUH, PO Box 120, Saskatoon, Saskatchewan S7N 0W8, Canada (e-mail: symposium98@usask.ca; web site: www.usask.ca/medicine/agmedic/symposium98.html).

Notice to authors: a new section—Brief reports

All editors would like to publish as many worthy papers as possible, with minimal delay. To facilitate this, in future, the journal will include a section entitled “Brief reports”. These will be peer reviewed and when approved, publication will be expedited. Please note: papers being submitted for this section should not exceed 1500 words.
Injuries in less industrialised countries

Alfredo Celis

*Inj Prev* 1998 4: 162
doi: 10.1136/ip.4.2.162-a

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