REGIONAL REPORTS

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 interested, forward-thinking agencies. 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:

“Representatives from Ethiopia, Kenya, Uganda, Zambia, Zimbabwe, South Africa, and the World Health Organization (WHO) met on December 15–17 in Entebbe, Uganda at the joint WHO/Injury Control Centre Uganda (ICC-U) and the United Nations Regional Group Meeting on Injury Prevention and Control in East and Southern Africa. Participants focused on the health sector issues of injury surveillance emergency medical systems, and health professional training in injury epidemiology and trauma care. A set of recommendations was formulated which has the potential to be a milestone for injury prevention in Africa.

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 consideration of adoption on 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 Kampala score), victim and event information, and intentionality. Operate definitions for the registry have been written, and the form has already been tested in Uganda and Ethiopia. The trauma registry form is sufficient for base line injury measurements while at the same time keeping the form short and simple enough for a range of health workers to fill out”.

Contact details for ICC-U: Dr Olive Kobusingye, Makerere Medical School, PO Box 7072, Kampala, Uganda (fax: +256 41 530022; e-mail: olive@imul.com).

DAVID BASS
Department of Paediatric Surgery, Red Cross War Memorial Children’s Hospital, Rondebosch 7700, South Africa

Editor’s note: While most Regional Reports have come from regular contributors—our team of Regional Editors—I am always delighted to receive contributions, regular or otherwise, from others, especially from parts of the world where we do not have Editorial Board members. Please send your contributions to the editor, Barry Pless.

Pedestrian and bicyclist safety in New York City

Pedestrian and bicyclist safety in New York City (NYC) has been in the news lately. Mayor Rudolph Giuliani has raised the ire of NYC residents by increasing the fine for jaywalking from $2 to $30, plus making a court appearance mandatory for paying fines for this offense. In addition, the mayor has recently announced that pedestrian barriers which separate pedestrians and vehicles at certain intersections will be kept up “indefinitely”. Anyone who has walked or driven the streets of New York know that its pedestrians are among the most aggressive in the world. The scene from the Midnight Cowboy in which Dustin Hoffman screams to an incensed driver, “I’m walking here in the attitude of the New York pedestrian, but only a little. Pedestrian and bicyclist injuries are a serious and sizeable problem in NYC city. There was a 23% increase in the number of pedestrians and bicyclists killed in motor vehicle crashes in NYC last year, from 249 in 1996 to 302 according to preliminary police statistics for 1997, 3700 hospitalizations annually, and an estimated 10 000 pedestrians struck by motor vehicles but not hospitalized. Between 1994 and 1996 pedestrian deaths due to motor vehicles declined slightly from 223 to 213. In this same period motor vehicle occupant deaths decreased more substantially from 207 to 169. Despite the pedestrian and bicyclist deaths, a study by Transportation Alternatives, a NYC watchdog group, found that most of the $400 million of New York State and NYC funds earmarked for transportation safety in the next few years will go to improve the safety of vehicle occupants rather than the safety of pedestrians and bicyclists.

From a public health perspective, enforcement of laws as well as use of physical barriers to separate pedestrians and vehicles are perfectly respectable counter measures against pedestrian injuries. Some of the uproar is because the least lethal players in the urban drama, the pedestrians and bicyclists, feel they are being unfairly and illogically singled out. And, of course, other measures could and should be taken, including enforcement of speed limits, use of speed bumps, creation of walking streets in heavily congested areas, and stricter licensing of taxi drivers. But the public ridicule that has been heaped on the Mayor is a reminder of the critical role played by the social context in which environmental and behavioral interventions are launched.

POLLY E BIJUR
Kennedy Center, Room 920, Albert Einstein College of Medicine, 1410 Pelham Parkway South, Bronx, NY 10461, USA

British green papers highlight injury prevention

In February 1998, the British government published two green papers (consultative policy statements) for England and Scotland: Our Healthier Nation and Working Together for a Healthier Scotland. These outline a strategic approach to public health that build on earlier target setting exercises that have met with limited success.

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 and environmental, and economic, 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 area 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!

DAVID STONE
The PEACH Unit, Department of Child Health, Yorkhill Hospital, Glasgow G3 8SJ Scotland, UK

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 all but one of all officers was absconded. 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—certainly where 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 a specific kind of device, which is inappropriate to 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 spate of casualties 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 due to 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 to frame sound planning 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 conditions 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 inexpensive prefabricated plan which creates lots 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 resorted to, or designated as a “cop out”, or even worse, as a quick fix.

DAVID BASS
Department of Paediatric Surgery, Red Cross War Memorial Children’s Hospital, Rondebosch 7700, South Africa (e-mail: DvB@ Netlab.shcape.gov.za)

1 Shield J. Have we become so accustomed to being passive that we’ve forgotten how to be active? Inj Prev 1997;3:243–4.

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 ranked 20th. This is the leading single 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 large 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 windsurfing may be priorities in areas in the EME, in low income countries attention must need to paid to drowning in streams, 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 EME countries, 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 dangers, closer 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 approach, it 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).

DINESH SETHI
ANTHONY ZWI
Health Policy Unit, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK


Injuries in less industrialised countries

EDITOR,—I read with interest the report by Mohan published in December.1 I agree that “Priorities for injury control have to be based on intelligent assessments of official statistics. This is what prompted me to draw attention to the improper use of the word “rate” as presented in the second paragraph, where the author writes “…the rate in India (8.6) is...” in reference to table 1 “Distribution of deaths as a percentage of regional total”.

Rates and proportions (expressed as percentages) are different. A rate is the ratio of two different quantities (generally symbolised by the equation a/b) while a proportion is the result of dividing two quantities where the numerator forms part of the denominator (symbolised by the equation a/(a+b)). A proportion multiplied by 100 is a percentage. Rates and proportions are not synonyms. It seems the author meant to talk about proportion and not “rate”. This mistake could confuse those beginning in the field of epidemiology, prompting them to think that “percentage” and “rate” are synonymous, they are not.

ALFREDO CELIS
Public Health Department, CUCS, University of Guadalajara, Sierra Mojada 8950, Colonia Independencia, Centro Medico, 44242, Guadalajara, Jalisco, Mexico


BOOK REVIEW


In Target Risk, Professor Gerald Wilde of Queen’s University in Ontario, Canada assembles an impressive body of theory and evidence to support a provocative conclusion: the only effective strategy for achieving substantial and durable reductions in the rate of injury in a population is to increase people’s desire to be safe and healthy. Traditional measures of injury prevention—engineering, education, and enforcement—are doomed to failure because they do not alter the “target levels of risk” that govern risk-taking behaviors. The process of “risk homeostasis” will ultimately undermine all non-motivational countermeasures, since people will alter behaviors to achieve an equilibrium between the overall amount of risk they perceive and their overall desired level of risk. The key to success, Wilde argues, is “expectationism”: promoting people’s interest in their future wellbeing in order to motivate adoption of smaller risk targets.

D. SETHI
A. ZWI
Health Policy Unit, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK

Wilde hints that any long term progress that
laws, you name it! Even more provocatively,
design improvements, motorcycle helmet
downs on drinking and driving, highway
measures: seatbelt laws, antilock brakes, traffic
densities of most mainstream injury prevention
more care. Using variations on this adapta-
respond by slowing down and driving with
When road conditions deteriorate (due to ice
highways are built, drivers trade some or all of
their speed for increased safety. Under these
conditions, Wilde characterizes the effective-
ness of most mainstream injury prevention
measures: seatbelt laws, antilock brakes, traffic
densities of most mainstream injury prevention

One of the strengths of the pedestrian e-mail
network, PEdW, is its diverse back-
ground of the participants. Last month, a
physicist, Alan Streeter (ads4@lehigh.edu),
used his analytical skills to examine how
major newspapers covered 42 motor vehicle pedestrian collisions. 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 pedes-
trians (for example, "darted out"), or very biased
against pedestrians (for example, "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 ap-
ppeared to exonerate the pedestrian in any way.

Alan had a disturbing observation—that
newspaper reporters obtain their understand-
ing 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 conse-
quences of this bias may be more than just public
perception; this bias may also jeopardize the
pursuit of dangerous drivers. He also
recommended comparing international and
regional 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 under investigation, imply-
ing 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 Light-
stone's recent 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 PEdWNET partici-
pants provides insight into addressing driver
behavior. Osias Baptista Neto (techtran@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 pre-
liminary data showed a 70% drop in casualties in
the major cities like Sao Paulo, Belo Hori-
zonte, and Curitiba. His report illustrates the
benefits of global comparisons of injury con-
trast effects. Of course, he further connects the
English speaking world, but extra effort is
required to reach beyond the barrier of differ-
ing 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

John D Graham
Harvard School of Public Health,
Boston, USA

Injury Prevention 1998;4:163

PEDNET

PETER JACOBSEN
PO Box 712433,
Los Angeles,
CA 90071-7433, USA

Correction

We regret that a production error occurred
in the March issue; this resulted in three
differences in text:

1. Lightstone AS, Peak-Asa C, Kraus JF. Relationship
between driver's record and automobile
legalsystemstreatmotorvehicleinjuries.

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Injuries in less industrialised countries

Alfredo Celis

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_http://injuryprevention.bmj.com/content/4/2/162.2_

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