Consumer activism pays big dividends in USA

Homer said that "The mark of wisdom is to read aright the present, and to march with the occasion". In this regional report from the US, I commend those businesses and media outlets in America who have had the wisdom to listen to the concerns of injury prevention advocates and to either voluntarily withdraw their questionable products from the market and/or to change their advertising strategies. A few examples from various injury risk areas follow.

Newweek (choking prevention)

In spring of 1997, *Newweek* published a special edition entitled, "Your Child From Birth to Three". One chart called "Building Health Habits" contained a serious error. It said that 5 month old babies could hand feed themselves zwieback or raw carrot chunks—a clear choking hazard for young children. In response to the concerns of the safety community, *Newweek* published a corrected version of the chart in a subsequent issue, promising to send corrected versions of the early childhood issue to newstands, hospitals, and doctors' offices. Any subscriber who wanted a corrected version of the chart was invited to call a toll-free number.

Mattel (toy safety)

In 1996, Mattel introduced the Cabbage Patch Snacktime Kids who were supposed to munch on plastic cookies and French fries. About 500 000 dolls were sold. In response to media reports that the snacking doll preferred to eat children's hair and fingers, Mattel pulled the dolls off the toy store shelves, ordering retailers to return any unsold dolls and offering $40 refunds to any dissatisfied consumers who had bought the dolls.

Haggar pants (fire prevention)

In 1997, Haggar Clothing Manufacturers produced a commercial in which a man re-enters a burning building to retrieve his pants. Upon seeing this ad, a New York fire chief called Haggar to complain that the fire safety community spends considerable time and energy trying to teach the public to "get out and stay out" of a burning building (personal communication). The fire chief alerted the National Fire Protection Association as well, and working together, they convinced Haggar to pull the ad immediately.

Northwest Airlines (drowning prevention)

On 26 April 1997, *USA Today* published a Northwest Airlines ad which depicted a child being drowned in a five gallon bucket. The copy read, "Great summer savings on Northwest Airlines. Looking for a new vacation spot? Ann Brown of the US Consumer Product Safety Commission called the Chief Executive Officer of Northwest and he agreed to pull the ad immediately. As a result, the ad ran only once anywhere—in that issue of *USA Today*. In addition Northwest published an article on hidden hazards in the home in its September 1997 in-flight magazine, *World Traveler*. Unfortunately, the same stock photo ran again in an advertisement for Nature's Solutions herbal supplements in the February 1999 issue of *Parenting*. The editor printed an apology in a later issue, stating that "we regret that the picture stepped though our normally stringent ad review process. Nature's Solutions has stopped using the ad, and has appointed a child safety advocate to review all of its promotional and advertising materials."

My thesis is that every single one of us in the injury prevention community can make a difference in influencing corporate America. Taking five minutes to communicate our concerns about a new product or its promotion in writing or by telephone is no little thing, but rather can produce tremendous results in the safety arena. As Ralph Waldo Emerson said, "Sometimes when I consider what tremendous consequences come from little things—a chance word, a tap on the shoulder, or a penny dropped on a newstand—I am tempted to think there are no little things."

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In May, Portugal became the first EU member state to publish a law forbidding unsupervised children, lack of seat belts, and poorly located bus stops. Even babies and children under 3 years old when they go to daycare centres are carried in buses or minibuses without any kind of restraint. APSI has written to the Prime Minister about it but nothing has changed. The Ministry of Health is concerned about it, and in its strategies for the year 2002 it aims to have a law defining minimum requirements for the safe transport of children.

Children in cars

It is still possible to buy child restraints to the now out of date European regulation R44.02 in Portugal, mainly old models from Portuguese manufacturers. APSI has been undertaking regular surveys of the way children are carried in cars. The most recent was in June 1999, and although the number of children properly restrained is slowly rising, it is still very low—only 21% of children under 12 are properly restrained. For children aged 3 years and under, half of the children were restrained although the observers, who were checking from outside the vehicle, reported that one third of these are obviously misused. The main errors noted were infant seats facing forward, infant seats lying on the car seat without being restrained, children unrestrained while the seat is restrained, and children restrained in an unrestrained seat!

Accident prevention in Portugal's health strategies

The Ministry of Health has published the Strategies for Health including targets for a reduction by 2007 of 30% in road crash deaths and a reduction in injuries at home and school during leisure activities. The targets for 2002 include a fall by 15% of the road accident mortality rate by raising of restraint use, legislation for safe school bus transportation, compulsory use of cycle helmet and other issues related to cycling.

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Injury surveillance in Northern Ireland

A recent development in Northern Ireland shows much promise for injury control in the province. A new electronic injury surveillance system has been introduced at the Royal Belfast Hospital for Sick Children, our only paediatric hospital. Information on the cause of injury is being collected on all children presenting to the accident and emergency department. The first six months' data has been examined for completeness and accuracy.
A memorial to Colonel John Stapp

Colonel John Stapp, whose sled testing resulted in the basic design for present day safety harnesses, died recently. Sue Baker writes below about a fellowship in his memory.

The death of Colonel Stapp leaves a big hole in our universe. The gap will always be there. Colonel Stapp was a leading force in the next generation of leaders, the Johns Hopkins Center for Injury Research and Policy has established the John Paul Stapp Endowed Fellowship. Interest from the endowment will go to students who wish to research and study focus on aviation safety, highway safety, or biomechanics—areas that have benefited greatly from Colonel Stapp’s historic research.

Contributions of any size will be welcomed. Gifts of $500 to $2500 will be matched by faculty members at the Johns Hopkins School of Public Health. A gift or pledge of $50 000 or more payable over five years to the Stapp Fellowship will be matched by a gift from Michael Bloomberg, chairman of the Johns Hopkins University Board of Trustees. In addition, up to 10 bequests or planned gifts of $100 000 or more will be matched through the Bloomberg Challenge.

For more information about the endowment contact Sue Baker (tel: +1 410 955 2078 or e-mail: sbaker@jhsph.edu). Contributions or pledges to Johns Hopkins University, earmarked for the Stapp Fellowship, can be sent to the Johns Hopkins University School of Public Health, 614 N Wolfe St, Baltimore, MD 21205, USA.

BOOK REVIEW


This book comes with a comment form so that readers can evaluate its worth. I found this a very useful starting point when reviewing the text and would encourage everyone else to use it too. As a researcher and practitioner who has had experience of evaluating injury prevention programmes, I was interested to see what this United States text has to offer, and how applicable it is to the UK.

The purpose of the book is to help those working in injury prevention understand (1) why evaluation is worth the resources and effort involved, (2) how evaluation is conducted, and (3) how to incorporate evaluation into programmes.

The book is divided into three main sections as outlined above. Section one is brief but covers important issues such as why evaluate, what components go into good evaluation, who should conduct evaluations and what type of information evaluation will provide. In general the content of this section is good, however, is not always easy to follow as it often refers to pages further on in the book. The least useful element of this section (for me) is the part that looks at “choosing the evaluator”. I believe most people reading this book will be doing so because they themselves will be carrying out an evaluation, or teaching others how to evaluate—not hiring an evaluation consultant.

Section two describes each of the four stages of evaluation: formative, process, outcome and impact stages. The most appropriate time to carry out each stage. There is a wealth of valuable, important, and relevant information in this section, particularly the comprehensive descriptions of each of the stages of evaluation. It is ideal as a reminder, and for anyone who is not clear about different types of evaluation and why each method is appropriate at different stages of a programme.

The methods for conducting evaluation that will help any reader carry out simple evaluation are dealt with in section three. Again, this section contains comprehensive and valuable information on various qualitative and quantitative methods which could be used to evaluate programmes. It is also encouraging to see that both the qualitative and quantitative methods are given equal importance. The quality of the information in this section is well balanced and is perhaps most appropriate for personnel who are not that familiar with evaluation methods. Any more detail would deter a beginner from ever evaluating anything! One of the most useful elements of this section is well balanced and is perhaps most appropriate for personnel who are not that familiar with evaluation methods. Any more detail would deter a beginner from ever evaluating anything! One of the most useful elements of this section is the extensive and well structured checklist of tasks that can be used for reference. Appendix B, the glossary, is absolutely essential for anyone starting out in the evaluation of unintentional injury prevention programmes, and appendix D contains a basic bibliography.

On the whole I think this is a good resource for practitioners in the field of injury prevention. I do feel, however, that the book tries to cater for too wide an audience—for those with little or no experience of evaluation, to those who will use it as a teaching tool. The quality of the information is taken from being very useful and relevant, to extremely basic and perhaps a little condescending to the reader. Despite these criticisms I would definitely recommend this book to practitioners for personal reference. I would suggest, however, it would be best used as a teaching resource for injury prevention coordinators who are training others in programme evaluation.
 brings together people across cultures to discuss and learn from one another, bridging the gaps in understanding and promoting a shared vision for injury prevention. The conference encourages collaboration and the exchange of ideas, fostering innovative approaches to address the complex challenges of injury prevention.

Injury 2000 Prevention and Management
19–25 November 2000, Canberra, Australia. Further information: Injury 2000 Prevention and Management, PO Box 1280, Milton, Queensland 4064, Australia (tel: +61 (0) 7 3858 5410; fax: +61 (0) 7 3858 5510; e-mail: injury2000@im.com.au).

10th International Conference on Safe Communities
21–23 May 2001, Anchorage, Alaska. This conference will focus on the opportunities in the new millennium for community-based injury prevention programming. Further information: Diana Hudson, PO Box 210736, Anchorage, Alaska 99521, USA (tel: +1 907 929 3959, fax: +1 907 929 3940).

Nordic Safe Community Conference
21–24 August 2001, Denmark. Further information: Moa Sundström, Karolinska Institutet, Department of Public Health Sciences, Division of Social Medicine, Norrbacka, 2nd Floor, SE-171 76 Stockholm, Sweden (fax: +46 8 33 46 93, e-mail: moa.sundstrom@socmed.sll.se).

Honorary editors honoured
Not one but two of our honorary editors have been honoured. We are proud and delighted that Sue Baker has received the American Public Health Association Award for Excellence and Hugh Jackson will be the recipient of the James Spence Medal from the Royal College of Paediatrics and Child Health. In both cases these awards signify not only that the recipients’ peers recognise their contributions to their respective disciplines, but also that the field of injury prevention is one worthy of such recognition, largely as a result of their efforts.

LETTERS TO THE EDITOR

Open invitation from the International Poverty and Health Network to all health professionals
EDITOR,—Always and everywhere, the challenge for all health professionals is to understand, from a position of relative comfort, the nature and extent of the problems faced by the poor, the marginalised, and the vulnerable. Understanding, once even partially achieved, creates empathy and a responsibility to advocate for redress. The International Poverty and Health Network (IPHN) was created in December 1997, following a series of conferences organised by the World Health Organisation (WHO). The aim of the network is to “integrate health into poverty eradication policies and strategies, promoting commu-
difference in 1970–72 to almost a threefold difference in 1991–93.

It is a matter of particular concern that the lives of so many children are blighted by pov-
erty and robbed of their physical and mental potential. Even in the USA more than one in four
children under the age of 12 have difficulties in obtaining all the food they need.
II health and poverty are mutually rein-
forcing and can generate a vicious cycle of deterioration and suffering. Ill health contrib-
utes directly to reduced productivity, and in some cases, to loss of employment. When it
affects the principal earner in poor families it frequently has severe implications for eco-
nomically dependent children, and other family members, who may no longer be able to
nourish themselves adequately. By defini-
tion, poor people have very few reserves and
may be forced to sell what assets they have,
including land and livestock, or borrow at
high interest rates, in order to deal with the
immediate crisis precipitated by illness. Each
option leaves them more vulnerable, less able
to recover their former condition, and in
greater danger of moving down the poverty spiral. In contrast, effective and accessible health
services can protect the poor from spir-
alling into worsening economic problems
with the onset of illness, and community
based health care has the potential to make
a major contribution to the building of social
capital and to the strengthening of the
community's own coping mechanisms.
In the 20th century development was all
too often equated with economic growth, but
the link between economic prosperity and
health, a key component of human develop-
ment, is not automatic. A recent World Bank
study of the causes of declines in mortality
between 1960 and 1990 suggested that gains
in income contributed around 20% to male
gains in income contributed around 20% to male
gains in income contributed around 20% to male
gains in income contributed around 20% to male

The researchers indi-
cated that educational level among women
and the generation and utilisation of new
knowledge were more important factors.
Poverty is a social construction with many
dimensions, including lack of basic education,
inadequate housing, social exclusion, lack of
employment, environmental degradation,
and low income. Each of these diminishes
opportunity, limits choices and undermines
health, and poses a threat to health. Eco-

It is health, rather than economic, indi-
cators which will demonstrate the importance of implementing policies across a range of areas to slow the rate of depletion of
resources and, through the securing of human rights, to capitalise on the
potential of those who are currently unable to improve their quality of life.
Health professionals strive to understand
the detail of their patients' experience
of illness and distress. Where health is being
undermined by poverty, this understanding
becomes as, we share our patients' frustration and
anger, part of a process of developing
solidarity with disadvantaged individuals and

For more information about the IPHN, please con-
tact: International Poverty and Health Network, Health Link Worldwide, Cityside, 40 Adler Street
London E1 1EB, UK (tel: +44 (0)207 539 1570, fax: +44 (0)207 539 1580, e-mail: (Roger Drew)
drew.r@healthlink.org.uk) or International Poverty
and Health Network, Health Cell, Society for Community Health and Awareness, Research and Action, No 326, 5th Main, 1st Block,
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Judith A Oulton, Chief Executive Officer, Inter-
national Council of Nurses; Dr Claudia Ribeiro,
Associate Professor, Department of Paediatrics and
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Versions of this editorial are being published in
different journals worldwide.

Let's emphasize fire sprinklers as an
injury prevention technology!

EDITOR.—The recent article by Lynne Warda
et al did a generally excellent job of reviewing
the literature on prevention of fire injuries.1
Perhaps because the keywords did not include
“sprinkler”, the researchers reportedly
neglected the tremendous value of automatic
fire sprinkler systems in preventing deaths and
injuries in house fires. The National
Institute of Standards and Technology esti-
mates that while smoke detectors alone can
reduce the fire death rate by 52%, sprinklers
alone could reduce deaths by 69% and the
combination by 82%.2

Sprinklers protect people without requiring
human action after a fire starts, and
therefore go a major step beyond smoke
detectors. Detectors can alert people to a fire,
but fail to protect anyone who cannot easily
escape. Automatic sprinkler systems are
designed to act instantly. Detectors do nothing
directly to save lives; they alert people just
to escape. Sprinklers protect people without requir-
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fires in homes with sprinklers and 126,240 non-arson fires in homes without sprinklers for the same fire departments. Preliminary results of research, which included validation of the outcomes and sprinkler status with the reporting fire departments, by Kay, one of the authors, indicate that the sprinklered homes had no fatal fires and 3.9 non-fatal injury fires per 1000 fires. In contrast, the non-sprinklered homes had 8.0 fatal fires and 36.7 non-fatal injuries per 1000 fires.

In recent years, some jurisdictions in the United States have mandated sprinkler installation in new single family or multifamily housing. Yet many builders and homeowners are discouraged by myths and misconceptions, including a belief that sprinklers will “go off” by mistake and cause extensive water damage. In fact, sprinklers rarely activate accidentally and they sprinkle only rooms where there is fire. Not only do sprinklers improve life safety conditions by extinguishing a fire soon after onset, sprinkler discharges of 30 gallons/minute cause much less property damage than fire hoses at 300 plus gallons/minute.

Many people also think that sprinklers are too costly, but advances in quick response sprinkler technology have improved performance and reduced costs through the use of plastic pipe. The installation cost ($1.50 per ft of finished floor space) in a new house can be gradually recovered by reductions in insurance premiums.

Installation of automatic sprinkler systems in all new dwelling units and retrofitting in high hazard locations should be a high priority goal of the next decade.

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Argument for accident and emergency (A&E) collection flawed

Editor—In a recent edition of Injury Prevention, Leonard and colleagues argue that the monitoring of recent changes in bicycle road safety policy in Scotland require “accurate measurement to generate robust findings” (p303). Regrettably what they propose, “a national computerised data collection system for all A&E [accident and emergency] departments” (p304), will not meet their specification. This is primarily because there would be many cyclists who do not attend A&E who have injuries of similar anatomical or physiological severity to those that do attend. There is evidence that the probability of attendance at A&E depends on factors other than injury occurrence, including demographic and access factors such as distance from hospital.1 Equally important is that delivery of A&E services may change within and across providers over time in response to changes in health service policy and practice.1

If Scotland wishes to monitor the impact of its transport policy on injury to bicyclists it needs an indicator which ideally meets the following criteria:

1 The indicator should reflect the occurrence of injury satisfying some case definition of anatomical or physiological damage.
2 The injury cases ascertained should be important in terms of incapacity, impairment, disability, quality of life, cost, and/or threat to life.
3 Cases should be completely ascertained from routinely collected data.
4 The probability of a case being ascertained should be independent of social, and of health services supply and access factors.

An indicator based on all attendances for injury at A&E departments will not satisfy these criteria. We have argued that, in the context of routinely collected data in England, a reliable indicator is one based on identifying cases of serious long bone fractures admitted to hospital.2 This indicator may be a useful starting point for the measurement of recent changes in bicycle road safety policy where, like in England and Wales, no direct measures of injury severity are routinely collected.

A national computerised data collection system for all A&E departments in Scotland is likely to be expensive. A better use of any additional resources would be to introduce severity coding of injury admissions, and to use an indicator based on serious injury cases to monitor the effect of this and other policy changes.

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Foam party risks

Editor—Foam parties are becoming increasingly popular among young people. A male adolescent aged 16 years tried to leave a dance floor covered with several feet of party foam. Because of the slippery foam he lost his footing and stumbled to the left. He fell and hit his head on a metal bar placed at the edge of the dance floor. He got up but he soon became somnolent and retrograde amnesia occurred. Because of the foam nobody could see the circumstances of the fall and he was taken outside to recover. Consequently his transport to an emergency department was delayed.

At admission a small skin bruise at the occiput was noted. Because of increasing headache and clinical signs of increased intracranial pressure he was referred to our hospital for further treatment the second day after the accident. Computed tomography at admission demonstrated a significant right frontal intracerebral haematoma with perifocal oedema, a small right frontal subdural haemorrhage, and a midline shift to the left (fig 1). He was monitored in the intensive care unit with an epidural intracranial pressure transducer. The initial recovery was uneventful and he was discharged home two weeks after the injury. However, he had lost smell and taste perception and his short term memory remained disturbed at follow up six months later.

Young people should be made aware that party foam sprayed on a dance floor creates a very slippery surface and the potential for accidents may be imperceptible to others when several feet of foam cover the floor. Foam parties can also cause significant chemical keratoconjunctivitis when the foam containing anionic tensoactives comes into contact with their eyes.1,2

We therefore recommend that party foam should be used only when there is adequate supervision of the dance floor. The edges of the floor should be rounded and made of impact absorbing material. Party foam must not be sprayed onto the faces of people dancing.

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Open invitation from the International Poverty and Health Network to all health professionals

Iona Heath and Andy Haines

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http://injuryprevention.bmj.com/content/6/1/71

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