Parent awareness and attitudes survey

From the Alberta SAFE KIDS Campaign, a report of a telephone interview survey with 276 parents of children under age 15. Surprisingly, perhaps, 'accidents' were viewed as the most worrisome risk to children — named by 44% of respondents. Altogether 25% reported their children had an injury requiring medical attention within the past year but only about one half of these parents thought the injury could be prevented. More than 80% of parents favoured bicycle helmet legislation for children (Joanne Vincenten, Edmonton; Carol Beringer, Alberta).

Fact sheets from SAFE KIDS Alberta

An excellent set of fact sheets from Alberta SAFE KIDS Campaign are available on the following topics: child safety seats, trampolines related injuries, toy safety, bicycle safety, poisonous plants, home safety checklist, child pedestrian injury, and playground safety. These are well designed, cleverly and concisely written, and make good use of a simple three column, three colour format (JV).

Child Safety News

The June 1996 issue, edited by Jan Shield, and originated from the Royal Children's Hospital Safety Centre (Flemington Road, Parkville 3052, Victoria, Australia) concentrates heavily on transport issues. Among the more controversial issues excerpted are school bus safety, cost effectiveness of compulsory bicycle helmets, a for and against debate on cycle helmets for children, seatbelt use and income, airbag associated fatal injuries, adult accompaniment and risk of pedestrian injury. If you only have time to read one 'journal digest', this is the one I recommend.

Hazard

Published by the Victorian Injury Surveillance System (VISS) the March issue has an article on 'second generation injury surveillance' — the move to electronic methods of data collection and entry. In the lead article, Watt and Ozanne-Smith state that surveillance data collection is required at three levels: statewide, using a national minimum dataset, comprising level I; a smaller number of hospitals providing more variables information at greater depth (like the current VISS paper based system), comprising level II; and level III, including both of the former alongside additional data for specific injuries, activities, locations, and product types obtained by follow up telephone calls. This issue of *Hazard* also includes an interesting report on dog bites: nearly one half of the 260 hospital admissions after such bites (100 to be exact) involved 1–4 year old children.

Safe Community News

An interesting feature in a recent release of *Safe Community News*, by Josie Livingstone, Safe Castlemilk, a housing estate in Glasgow, Scotland, describes the concern felt at the prospect of World Health Organization Safe Community accreditation — that people might become complacent and the 'we would be over-reaching ourselves' in maintaining the standards set. Nevertheless, Livingstone reports that they 'found the accreditation process empowering'. She adds, 'For Safe Community accreditation to be more influential, community safety needs to be placed more in the mainstream ... [it needs] the same prominence and political backing as Healthy Cities'.

Morbidity and Mortality Weekly Report

This report from the CDC in the US (7 June 1996) includes a sobering summary of trends in rates of homicide in the US from 1985 to 1994. Altogether 71% of the 26 009 homicides reported in 1993 were firearm related, and one third of the total involved 15–24 year olds. Also in this issue is a report on work related injuries and illnesses associated with child labor in 1993.

Insurance Institute for Highway Safety (IIHS) 'Status Reports'

The May issue of this IIHS publication has a feature on side impact airbags, predicting that they will 'be in lots of cars very soon'. It lists the manufacturers and models in which they intend to introduce these devices as standard equipment. Another feature deals with the poor enforcement of minimum purchasing age laws for alcohol in the US (*Public Health Reports* 110:4). Despite this, the report of a survey (*Public Attitude Monitor* 1995) shows strong support for zero tolerance laws and graduated licensing programs, as well as night time driving curfew laws, for those under 18 years. In a separate study by AF Williams *et al*, comparing belt use rate by high school students in 1980 with 1995, it appears use rates have increased but still remain too low, especially among teenage passengers. Most intriguing is the wide variation in driver belt use rates — from 36 to 91% depending on the school surveyed. Finally, as should have been expected, after federal maximum speed limits were abolished, drivers are going faster and breaking the new speed limits on urban freeways.

LETTERS TO THE EDITOR

Third International Conference on Injury Prevention and Control

EDITOR,—The various comments concerning the Third International Conference on Injury Prevention and Control scattered throughout the June 1996 edition of *Injury Prevention* are appreciated by at least one organiser. While I am pleased that the hospitality aspects of the conference were considered worth the expense of attending a meeting so far away, my purpose in writing to you is to respond to comments about the program and to suggest a new paradigm for thinking about the conferences.

One of my most interesting tasks was to triage all abstracts for review. More than most, I was able to see the broad spectrum of the submitted abstracts. As I read, I saw our intentions to schedule only excellent and innovative papers come falling around our ears. The reason? A large proportion of submitted papers consisted of injury incidence surveys. Many had intervention recommendations bearing no relation to the actual study, simply tacked onto the end. Others were program descriptive papers, many without rigorous evaluation.

While our conference objective was clearly to encourage interdisciplinary understanding, we also wished to ensure the conference series continued to develop scientific rigour. In addition we acknowledged that program personnel at the coal face of injury prevention action are often poorly resourced and

isolated; factors often resulting in less than optimal program evaluation. In the end fiscal pragmatism won out — we found a place in the program for all authors in the most creative way we could.

The question needs to be asked once again, 'What do we want from international conferences?' We know that health administrators look to conferences for evidence of 'what works'. They want to take advantage of work undertaken by others in order to transfer that knowledge into their strategic plans. While this makes pragmatic sense, it is also illogical. Comments by Forjuoh and Zwi,^{1,2} highlighting problems concerning the transferability of technology and prevention mechanisms from industrialised to low and middle income countries, point to the pitfalls of such pragmatism. There are similar difficulties involved in such transference between industrialised high income countries, simply because the political and cultural differences are great. We need skills to take injury control principles and apply them to our own political and cultural environments. It may be that the notion of 'what works?' is too simplistic a question to ask.

That being the case, what is it we should expect to get from international conferences? An occasion for debate? Professional training? Learning new skills? New ideas? For most of us all the above apply. The degree to which our expectations of future meetings are met will relate directly to the commitment of the injury prevention community to assisting the development of rigour, and ensuring the establishment of realistic goals in program planning and evaluation, together with commitment to the professional development of new players in the field.

The international injury prevention community will reap what it sows. It seems that many health administrators are reluctant to invest in sound evaluation of the injury prevention program they fund, and the result is beginning to show. We simply cannot continue to expect to benefit from the contribution of others without making a substantial contribution of our own. In addition, we can't expect to receive cutting edge evidence from short term programs run on a shoe string budget.

The Melbourne conference experienced degrees of cooperation from session contributors. One North American delegate filled out his program by agreeing to present the abstracts submitted by his colleagues who found they couldn't attend at the last minute. He must have been exhausted by the end of the conference. His commitment to the work of colleagues and to the integrity of the conferences was something I will not forget. He was one of many. At the same time, while the meeting was attended by almost one thousand delegates, I was disappointed to see inexperienced researchers and program personnel presenting their papers to almost empty rooms. From where can they expect to receive helpful feedback on their research/program methods if not from those who have gone before? (Maybe it said more about the weather and tourism opportunities in Melbourne!)

I suggest that a change of mindset is required. If experienced practitioners focused more on what they could contribute to the conference, rather than what they could get out of it, we may see rapid development reflected in the conference program. Contributions of such kind should be honoured. Maybe future conference organisers could consider ways in which this could be achieved.

The future for the development of injury control as a discipline is in our hands.

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- 1 Forjuoh S. Injury control in developing nations: what can we learn from industrialized countries [Opinion]? *Injury Prevention* 1996, 2: 90-1.
- 2 Zwi AB. Injury control in developing countries: context more than content is crucial [Dissent]. *Injury Prevention* 1996, 2: 91-2.

Fractures caused by bicycling

EDITOR.—Following the recent National Bike Week, we would like to report some current findings of an ongoing study of causes of fractures in 0-16 year olds in Swansea, Neath, and Port Talbot. This is not intended to make a case against cycling for young people, but rather to point to the need for proper equipment and, most particularly, education in the safe use of the bicycle.

For every person in the 0-16 age range receiving a new diagnosis of fracture of any bone during attendance at either of two accident and emergency departments information was sought regarding the location of the accident, activity at the time, and mechanism of the injury resulting in the fracture.

In the seven days Thursday 30 May to Wednesday 5 June, 61 new fractures were identified. The cause was known in 57 (93%) and 14 of the total (23%) were known to be due to bicycle accidents. Only one of these involved a car, which was stationary at the time. The injuries were fractures of the wrist, five; radius, one; elbow, two; hand, two; clavicle, one; mandible, one; nose, one; and parietal and frontal bones, one. Four children required admission to hospital.

Seven of these accidents occurred on the road, two on the pavement, one on rough ground, one on public grassland, one on a private driveway, one in a garden, and one location was unknown. These findings concur with those of Acton *et al* in Queensland, who found similar numbers of children injured in on-road and off-road sites, the commonest reason for injury being 'faulty riding'.¹

Bicycle accidents are by far the largest cause of fractures in this age group in the week described. These fractures are the tip of an iceberg of accidental injury to children, and it is clear that a high percentage of these injuries are eminently preventable. Let us advocate the use of the bicycle — but make sure that we take our advocacy role further in seeking safe cycle routes, excellent cycling education, and support for cycling safety equipment.

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- 1 Acton CHC, Thomas S, Nixon J, Clark R, Pitt WR, Battistutta D. Children and bicycles: what is really happening? Studies of fatal and non-fatal injury. *Injury Prevention* 1995, 1: 86-91.

Bicycle helmet use

EDITOR.—The important findings reported by Sacks *et al* (p258) are strengthened by some of our own. We validated cyclists self

reported helmet use by comparing questionnaire responses to documentation of helmet use in emergency department records and found a 96% positive and 96% negative predictive value for self reported use. Thus, it seems evident that self reports, at least of helmet use, are valid.

We also studied the relationship between helmet ownership, use, and age based on data from a recently completed case-control study of injured bicyclists treated in the emergency department or hospitalized at one of seven hospitals in the Seattle (USA) area between March 1992 and August 1994. The regional trauma center and medical examiner's office from two counties were included to ensure that serious injuries and deaths were included.

Riders were asked if they owned a bicycle helmet at the time of the crash (not necessarily involving a car collision) and if so, if they were wearing it when they crashed. Parents filled out a mailed questionnaire for children under 14 and subjects who did not respond by mail were interviewed by telephone. The response rate was 88% and showed that 76% of subjects owned helmets and 50.7% reported wearing them at the time of the crash. Helmet use was recorded in the medical record for 52.5% of the subjects treated.

As shown in the table below the ratio of use to ownership varied by age; the highest ratios were found in adult riders, the lowest in teenagers. If we assume that many of the adults are parents, this may help explain the unusually high rates of use found for children. These figures may also be high as a result of a 10 year multifaceted community wide campaign to increase helmet use in the Seattle area.

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Helmet ownership and use by age group at time of crash (n = 3390)

Age (years)	Owned helmet		Wore helmet	
	No in group	%	No in group	%
<6	190	75.4	120	47.6
6-12	938	77.1	544	44.7
13-19	365	67.0	175	32.1
20-39	781	75.9	607	59.0
≥40	300	86.2	272	78.2
All ages	2574	76.0	1718	50.7

Health advice to travellers

EDITOR.—An item often neglected in health advice given to travellers is the potential for injury. This seems quite extraordinary when one of the greatest threats, often the greatest threat, to the life and health of travellers, is injury. This applies particularly to younger travellers.

This neglect has been recognised in a distance learning Diploma in Travel Medicine course which is being run by the Department of Public Health and Department of Infection and Tropical Medicine at the University of Glasgow.

One of the problems of contributing to such a course is the paucity of published research in the literature. There are many anecdotes and everyone has personal

experience of the problems but it is actually quite difficult to put together a structured series of lecture notes from which future diplomates may realistically advise their patients and clients on what is important and what is trivial. Another problem is the wide variation of experience in different countries, some being far more hazardous than others.

In order to enhance my contribution to this diploma course, I would be interested to hear from any readers who have particular experience in this field and who might have material that I can use in my contribution to the course. Any material used will be acknowledged in the lecture notes issued to the diploma students.

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BOOK REVIEW

Amazing Grace: The Lives of Children and the Conscience of a Nation. Jonathan Kozol. (Pp. 249; \$23.00.) Crown Publishers, 1995. ISBN 0-517-79999-5. (Crown Publishers Inc is located at 201 East 50th St, New York, NY10022, USA.)

In 1994, Bernardo Rodriguez Jr, an 8 year old, fell four stories to his death in the elevator shaft of his apartment building at 140th Street near Cypress Avenue in the Mott Haven Section of the South Bronx, New York. His body was discovered when blood was observed dripping from the ceiling of the elevator.

Was the death of this child the result of an unintentional injury? Was this death preventable? Is assessing blame in such a case possible or useful? Children in this unit of the Diego-Beekman Building played in the hallways because the neighborhood around their project was terrorized by drug dealers. Clearly, the boy was engaged in risky behavior; is the 8 year old to blame? Bernardo was being supervised that day by his grandmother, who was in the apartment; his mother was in jail. Do these women bear the guilt of this death? Families had complained often that the elevator was frequently broken and that the door did not close properly. Should the city be held responsible? New York City had drastically reduced its public building inspection services as a cost saving measure. In fact, the city 'blamed' the family. Is the problem inherent in our societal 'system', rife as it is with economic injustice, racism, and prejudice?

The story of the death of Bernardo Rodriguez is part of the rich texture of *Amazing Grace* by Jonathan Kozol. The book provides a window into a world that few of us professionals have witnessed first hand. Coming up from the subway at the Brook Avenue station, with Kozol, we meet the children, their mothers and other relatives — mostly female — their religious leaders, and a series of other characters that inhabit one of the most distressed and disadvantaged landscapes in America. We are moved by the power of the narrative to bring human lives to life. We feel the pain and weep at the dignity and grace of these children and their families. Kozol doesn't make it easy for us. There is no list of problems nor facile solutions. This book is frustrating because there is no conclusion, no recipe for action. Those of us in the health