Community based interventions—less than perfect?

Thanks to Nixon et al1 and Moller2 for opening a dialogue on community based interventions. As learning organizations,3 we must continue to critically share evidence based and experiential work that faces real world constraints. I describe here how a “successful” but imperfect start up enterprise enhanced that field.

From 1976–84, my co-investigators and I received piecemeal funding for community based childhood poison prevention demonstration projects. (Two of the 12 resulting publications were cited in Medline.) Our Monroe County Project (MCP) intervention did not meet Nixon’s inclusion protocols as a true community study with cases and controls. Ours used a quasiexperimental design with school and parent education and the media to promote purchasing and using safer products. It was associated with a 66% decrease in hospital emergency department visits for those age 0–5 and 60% reduction in admissions compared with two pre-intervention years and to non-experimental comparison sites. Fewer accessible household toxic products and increased observed use of safety latches in homes of children under 6 were linked to significant knowledge gain and increased calls to the poison control center.

MCP findings of significant cost-containment: $25 dollars per project dollar spent, prompted an amendment to New York State Public Health Laws resulting in a State Regional Poison Prevention Network. This provided $4 million per year of Medicaid funding to designated regional poison control centers. It established regulations, annual reports, and an advisory committee. The MCP final report guided the Centers for Disease Control and Prevention’s Poison Control Advisory Group’s 1996 report for enacting a US regional poison control center enhancement funding law.

Experimental creative leadership during a period of downsizing resources can lead to significant scientific contributions to intervention systems tomorrow.4

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Sport safety research opportunity

A 2002 report of a United States Institute of Medicine workshop found that “no peer-reviewed studies have been published to support or refute the use of helmets in soccer and no authoritative medical or sports organizations have recommended the use of helmets in soccer.”1 However, in 2003, FIFA, soccer’s international governing body, and three leading national sports bodies in the United States—US Soccer Federation, National Collegiate Athletic Association, and National Federation of State High School Associations—reversed their traditional ban on padded headgear and began to permit use by any soccer player.2

Before the widespread adoption of soccer headgear makes it difficult to evaluate this latest sport injury preventive measure, now is a good time to start soccer headgear research projects in one or more states and countries.

A search of Medline combining “Head Protective Devices” and “Soccer” returned only four articles in English from 1966 through March 2004. Neither the Computer Retrieval of Information on Scientific Projects database of the National Institutes of Health (CRISP, accessed 6 April 2004 at www.nih.gov) nor the ProjectBank database of the National Association of Injury Control Research Centers (accessed 6 April 2004 at www.naicrc.org) listed any current or recent investigations of soccer headgear.

Sports related traumatic brain injury is an important public health problem because of the large number of cases each year, the generally young age of cases at time of injury, and the potential cumulative effects of repeated injury. Nonetheless, no new personal protective equipment is efficacious and effective.

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2 Hsiestrand M. Protective soccer headgear to debut in crowning event. USA Today 2003 September 4, C2.

About safety and safety promotion concepts

We were very interested in the comments of Nilsen et al on the “concept of safety” that appeared in a recent issue of Injury Prevention.3 The authors first address safety from a theoretical point of view, then from the perspective of intervention. A 1998 monograph about the concepts of “safety” and “safety promotion” are among the main sources cited by the authors.8 This monograph, an initiative of the World Health Organization (WHO), was prepared jointly by two WHO sponsored collaborating centers (Quebec WHO Collaborating Center for Safety Promotion and Injury Prevention and WHO Collaborating Center on Community Safety Promotion, Karolinska Institute), and is available in pdf format on the Institut national de sante publique du Que´bec’s website, in English, at http://www.inspq.qc.ca/pdf/publications/150_SecurityPromotion.pdf, and in French at http://www.inspq.qc.ca/pdf/publications/149_SecurePromotion.pdf. This document deals with the concepts of safety and of “safety promotion”. It offers a definition of safety promotion, and two distinct and complementary processes to promote its implementation: the problem based process and the setting based process. These two processes represent a “safety promotion approach”. An example illustrating this approach is presented at the end of the monograph. Over the past few years, two articles were published about this monograph in scientific journals.4

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BOOK REVIEWS

World Report on Road Traffic Injury Prevention


This impressive report aims to raise awareness about the extent of road traffic collisions
globally, to draw attention to their prevent-
ability, and to call for a coordinated part-
nership approach to addressing the problem. In its five chapters it gives in turn a comprehensive catalogue of the funda-
mentals of road safety, the impact of road un-
trauma across the world, the key factors con-
tributing to crashes and consequential injury.

LMICs are like HICs in that the enormous costs of road tra-
uma are valued at much higher levels than the costs of other health problems. HICs have begun to challenge their ab-
normal emphasis on motorised transport, and have begun to focus on policies that could be much lower priority to road safety than the unbridled growth in motorised transport, or the ineffective interven-
tions, even if they followed them uncrimi-
nally, the report is not critical of the LMICs, but it is not critical of the HICs either. The authors state that the LMICs need to really believe that the problem is preventable, that it is worth the substantial investment in the future, and that they need to share the responsibility with the public and private agencies. The failure in KZN was essentially due to the lack of investment in research and development in LMICs. The authors state that the LMICs need to share the responsibility with the public and private agencies. Partner-
ships, and shared responsibility, are key elements of the Victorian model of road safety program. The initial years of Project Victoria (later renamed “Asiphephe”) in KZN saw a 31% reduction in road traumas (from 1996 to 1998), but by 2001 road trauma had returned to 1995 levels. Perhaps one of the reasons was that it lost its commitment to Project Victoria (J Bodenr, personal communica-
tion) was that they saw it as essentially an LMIC approach, not adapted or suitable for local conditions or beliefs.

This is not to suggest that partnerships of public and private agencies are not a key factor in coordinating the range of organisations which would have responsibilities and resources for road safety in a typical LMIC. The failure in KZN was essentially due to the lack of investment in research and develop-
ment in local conditions to provide the back-
ground for the transfer of principles, and perhaps successful interventions. HICs, Partnerships, and shared responsibility for the road safety “system”, are key elements of Sweden’s “Vision Zero” strategy which is being seriously considered in LMICs to guide their future directions. Perhaps many LMICs would find the ultimate goal of zero road trauma impossible to achieve, but a realistic goal for their current resources. The target should not distract attention in either LMICs or HICs away from the systematic and cooperative aspects of the problem.

Notwithstanding these concerns about the LMICs making the same mistakes as the HICs if they follow them uncriti-
cally, the report is an excellent overview of what has been effective in road safety in HICs. The report also provides the basis for funda-
mental strategic thinking in the field, armed with which many LMICs may be able to reduce more quickly or even avoid their burgeoning road trauma problems.

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Drive On! A Social History of the Motor Car.

This is an entertaining, idiosyncratic history of the motor car written by a long time motoring writer. It looks at the way cars changed through the years and where to stop, then examines particular facets from hand cranking to computer control. For those interested in injury prevention, the most significant part of the book is that a history of the motor car can be written in a single indexed reference to seat belts, airbags, safety, alcohol, or traffic lights, slighting and dismissive references to seminal work such as Nader’s Unsafe at Any Speed, which is referred to as a “snide red rag” of a book, and no under-
standing of the huge social and economic cost associated with road death and trauma.

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CORRECTION

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Reality check: using newspapers, police report, and court records to assess defensive gun use

The above paper was published in the April issue (Inj Prev 2004;10:96–98) and the authors would like to correct some minor errors. In the second paragraph of the discussion the authors stated “The news-
paper reported two such homicides (both by security guards, one off-duty and the other on-duty)”; this should have read “…one such homicide…” In the abstract and key points where it states that there were two “DGUs [defensive gun uses] involving killing assail-
ants it should read “Two DGUs involving killing or wounding assailants”.

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