Community based interventions—less than perfect?

Thanks to Nixon et al. and Moller for opening a dialogue on community based interventions. As learning organizations, we must continue to critically share evidence based and imperfect experiences that face 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 quasi-experimental 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 prompted an amendment to New York State Public Health Laws resulting in a State Regional Poison Prevention Network. This established regulations, annual reviews of poisoning prevention projects in one or more states and countries.

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.


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 injuries. Nevertheless, not all new personal protective equipment is efficacious and effective.

D L Nordstrom
University of Minnesota Medical School, Department of Family Practice and Community Health, 925 Delaware St, SE, Suite 220, Minneapolis, MN 55414, USA, nordsl110@umn.edu
doi: 10.1136/ip.2004.005801

About safety and safety promotion concepts

We were very interested in the comments of Nilsson et al. on the “concept of safety” that appeared in a recent issue of Injury Prevention. 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. This monograph, an initiative of the World Health Organization (WHO), was prepared jointly by two WHO sponsored collaborating centers (WHO Collaborating Center for Safety Promotion and Injury Prevention, Geneva, Switzerland 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_SecuretePromotion.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.1,4

P Maurice, M Lavoie
Quebec WHO Collaborating Center for Safety Promotion and Injury Prevention, 2400 Etienne Bruneau, Beausport, Quebec, Canada G1E 7G9
Correspondence to: Pierre Maurice; pierre.maurice@ssss.gouv.qc.ca
doi: 10.1136/ip.2004.006080

References


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
trauma across the world, the key factors contrib-
uting to crashes and consequential injury
and death. Successful interventions have
to be put in place and sustained (which
have been applied (mainly in high income
countries) to reduce the problem, with the
final chapter containing conclusions and rec-
ommendations.

The report points out that over 3000 lives
are lost daily to road traffic collisions. While
a decrease in road deaths of some 30% is
foreseen in high income countries (HICs),
projected trends in low and middle income
countries (LMICs) for 2004-2008 foreshadow
an increase in road crash mortality between
2000 and 2020. Hence the report quickly
identifies that the priority globally should be
effective interventions in LMICs.

The fundamentals there is a recognition that "technology transfer
from high-income to low-income countries needs to fit local conditions and should address
research-based local needs". However chap-
ter 4, exposure management is the least used
of all road safety intervention strategies. This
is because, in HICs, there has been a funda-
mental belief in the high value of personal
motorised mobility, covering distance in the
minimum time consistent with comfort. Thus
considerations of cost and, and some extent, the
recommendations, seem to lose sight of this
message and dwell upon technologies which
have been evaluated only in HICs, as well as
new strategies which could be quite unsuit-
able to LMIC conditions. There is an impression
that the HICs have got it right in terms of
managing road trauma, and that LMICs should
follow the interventions and princi-
oples developed in HICs (albeit adapted to
local conditions or beliefs).

There are, however, at least two key areas
where HICs did not get it right during the
last 50-60 years when road transport became
both more available and cheaper and chea-
per for the general population and industry.
The first is that we have been reluctant to
manage exposure to risk. As noted in chapter
4, exposure management is the least used
of all road safety intervention strategies. This
is because, in HICs, there has been a funda-
mental belief in the high value of personal
motorised mobility, covering distance in the
minimum time consistent with comfort. Thus
considerations of cost and, and some extent, the
recommendations, seem to lose sight of this
message and dwell upon technologies which
have been evaluated only in HICs, as well as
new strategies which could be quite unsuit-
able to LMIC conditions. There is an impression
that the HICs have got it right in terms of
managing road trauma, and that LMICs should
follow the interventions and princi-
oples developed in HICs (albeit adapted to
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
domestic, international, and local conditions
and constraints. But the least successful (of which I
was one) misinterpreted KZN as ready for an
HIC-type road safety program. The initial
years of Project Victoria (later renamed
"Asiphephe") in KZN saw a 31% reduction
in road trauma (injury and deaths) between
1996 and 1998, but by 2001 road trauma had
returned to 1995 levels. Perhaps one of the
reasons the government and population of
KZN lost their commitment to Project
Victoria (J Bodinrarn, personal communica-
tion) was that they saw it as essentially an
HIC 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
domestic, international, and local conditions
and constraints. But the least successful (of which I
was one) misinterpreted KZN as ready for an
HIC-type road safety program. The initial
years of Project Victoria (later renamed
"Asiphephe") in KZN saw a 31% reduction
in road trauma (injury and deaths) between
1996 and 1998, but by 2001 road trauma had
returned to 1995 levels. Perhaps one of the
reasons the government and population of
KZN lost their commitment to Project
Victoria (J Bodinrarn, personal communica-
tion) was that they saw it as essentially an
HIC 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
domestic, international, and local conditions
and constraints. But the least successful (of which I
was one) misinterpreted KZN as ready for an
HIC-type road safety program. The initial
years of Project Victoria (later renamed
"Asiphephe") in KZN saw a 31% reduction
in road trauma (injury and deaths) between
1996 and 1998, but by 2001 road trauma had
returned to 1995 levels. Perhaps one of the
reasons the government and population of
KZN lost their commitment to Project
Victoria (J Bodinrarn, personal communica-
tion) was that they saw it as essentially an
HIC 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
domestic, international, and local conditions
and constraints. But the least successful (of which I
was one) misinterpreted KZN as ready for an
HIC-type road safety program. The initial
years of Project Victoria (later renamed
"Asiphephe") in KZN saw a 31% reduction
in road trauma (injury and deaths) between
1996 and 1998, but by 2001 road trauma had
returned to 1995 levels. Perhaps one of the
reasons the government and population of
KZN lost their commitment to Project
Victoria (J Bodinrarn, personal communica-
tion) was that they saw it as essentially an
HIC 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
domestic, international, and local conditions
and constraints. But the least successful (of which I
was one) misinterpreted KZN as ready for an
HIC-type road safety program. The initial
years of Project Victoria (later renamed
"Asiphephe") in KZN saw a 31% reduction
in road trauma (injury and deaths) between
1996 and 1998, but by 2001 road trauma had
returned to 1995 levels. Perhaps one of the
reasons the government and population of
KZN lost their commitment to Project
Victoria (J Bodinrarn, personal communica-
tion) was that they saw it as essentially an
HIC 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
domestic, international, and local conditions
and constraints. But the least successful (of which I
was one) misinterpreted KZN as ready for an
HIC-type road safety program. The initial
years of Project Victoria (later renamed
"Asiphephe") in KZN saw a 31% reduction
in road trauma (injury and deaths) between
1996 and 1998, but by 2001 road trauma had
return...