PostScript

LETTERS

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 less than perfect experiments that face real world constraints. I describe here 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 poisoning 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 in 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. 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.

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.”5 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.6

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, all new personal protective equipment is efficacious and effective.

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2 Hiastand 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.7 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 (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 lébec’s website, in English, at http://www.inpq.qc.ca/pdf/publications/150_SafetyPromotion.pd and in French at http://www.inspq.qc.ca/pdf/publications/149_SecuritePromotion.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.8,9

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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

www.injuryprevention.com
globally, to draw attention to their preventability, and to call for a coordinated partnership approach to addressing the problem. In its five chapters it gives in turn a comprehensive catalogue of the fundamentals of road safety, the impact of road trauma across the world, the key factors contributing to crashes and consequential injury, the successful interventions that have been applied (mainly in high income countries) to reduce the problem, with the final chapter containing conclusions and recommendations.

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 forecast in high income countries (HICs), projected trends in low and middle income countries (LMICs) foreshadow a huge increase in road crash mortality between 2000 and 2020. Hence the report quickly identifies that the priority globally should be effective interventions in LMICs. For 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 chapters on exposure, and to 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 unsuitable. 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 principles developed in HICs (albeit adapted to local conditions and constraints).

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 accessible and cheaper 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 fundamental belief in the high value of personal motorised mobility, covering distance in the minimum time consistent with comfort. Thus controlling exposure, and speed, have been given low priority compared to interventions which collectively could be seen as “patching up” the factors causing the crash and injury consequences of exposure and the kinetic energy derived from speed. It may not be too late for LMICs to challenge the unbridled growth in motorised transport, or at least to give much higher priority to managing exposure through land use policies and transport strategies in general (for example, separating road transport modes operating with disparate speeds and masses; discouraging unnecessary trips; and encouraging the use of safer and non-road travel modes). HICs have begun to challenge their own values in this area, as the costs of road trauma are valued at much higher levels than in the past. HICs should encourage LMICs not to make the same mistakes, by funding the real costs of road trauma against the intangible values of some elements of motorised transport, especially personal mobility.

The second key area where HICs did not get it right is that investment in road safety research and development has been relatively small in comparison with other types of health research and development has been relatively small in comparison with other types of health research and development. Of motorised transport, especially personal, against the intangible values of some elements of LMICs not to make the same mistakes, by the intervention strategies. This is because, in HICs, there has been a fundamental belief in the high value of personal motorised mobility, covering distance in the minimum time consistent with comfort. Thus controlling exposure, and speed, have been given low priority compared to interventions which collectively could be seen as “patching up” the factors causing the crash and injury consequences of exposure and the kinetic energy derived from speed. It may not be too late for LMICs to challenge the unbridled growth in motorised transport, or at least to give much higher priority to managing exposure through land use policies and transport strategies in general (for example, separating road transport modes operating with disparate speeds and masses; discouraging unnecessary trips; and encouraging the use of safer and non-road travel modes). HICs have begun to challenge their own values in this area, as the costs of road trauma are valued at much higher levels than in the past. HICs should encourage LMICs not to make the same mistakes, by funding the real costs of road trauma against the intangible values of some elements of motorised transport, especially personal mobility. The second key area where HICs did not get it right is that investment in road safety research and development has been relatively small in comparison with other types of health research and development has been relatively small in comparison with other types of health research and development. Of motorised transport, especially personal, against the intangible values of some elements of LMICs not to make the same mistakes, by the intervention strategies. This is because, in HICs, there has been a fundamental belief in the high value of personal motorised mobility, covering distance in the minimum time consistent with comfort. Thus controlling exposure, and speed, have been given low priority compared to interventions which collectively could be seen as “patching up” the factors causing the crash and injury consequences of exposure and the kinetic energy derived from speed. It may not be too late for LMICs to challenge the unbridled growth in motorised transport, or at least to give much higher priority to managing exposure through land use policies and transport strategies in general (for example, separating road transport modes operating with disparate speeds and masses; discouraging unnecessary trips; and encouraging the use of safer and non-road travel modes). HICs have begun to challenge their own values in this area, as the costs of road trauma are valued at much higher levels than in the past. HICs should encourage LMICs not to make the same mistakes, by funding the real costs of road trauma against the intangible values of some elements of motorised transport, especially personal mobility.