**LETTERS**

**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 experiments 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 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 provides $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 Disease Control and Prevention’s Poison Intervention Systems Tomorrow.

Period of downsizing resources can lead to significant scientific contributions to intervention systems tomorrow.

L Fisher
Safety/Management Consultant (Archivist, American Public Health Association, ICHES Section; see related commentaries at: www.icahs.org), 97 Union Avenue, South, Delmar, NY 12054, USA, fisher166@juno.com
doi: 10.1136/ip.2004.005801

**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.” 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.

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.naircc.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. Nevertheless, no 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, nords110@umn.edu
doi: 10.1136/ip.2004.005975

**References**


**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. 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, Montreal, and WHO Collaborating Center on Community Safety Promotion, Karolinska Institute), and is available in pdf format on the Institut national de sante publique du Quebec’s website, in English, at http://www.inspq.qc.ca/pdf/publications/150_SecuritePromotion.pdf 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.

P Maurice, M Lavioe
Quebec WHO Collaborating Center for Safety Promotion and Injury Prevention, 2400 of Estauverslie, Beaupre, Quebec, Canada G1E 7G9

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 preventability, and to call for a coordinated partnership approach to addressing the problem. In his 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. It also shows how interventions 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) for the next 50–60 years show a marked increase in road crash mortality between 2000 and 2020. Hence the report quickly identifies that the priority globally should be effective interventions in LMICs.

Accordingly, 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,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 to at least give much higher priority to managing exposure through land use policies, before too much harm has been done.

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 to at least give much higher priority to managing exposure through land use policies, before too much harm has been done.

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 loss (infectious diseases, etc.). The report identifies that funding for interventions, even in the HICs most active in road safety, has been scarce. Road safety efforts in HICs have failed to match the severity of the problem and continue to do so. There are good historical reasons why this was the case, including belief in the accidental nature of the problem and fatalistic acceptance of its inevitability, but the situation has changed. LMICs need to really believe that the problem is preventable, that it is worth the substantial investment in research and research based action programs, and that successful interventions from HICs cannot simply be transferred to each LMIC without research and development in local conditions. It needs to be recognized that this investment in prevention will need to be substantial, but ultimately, interventions should be aligned as other health program investments because of the enormous and increasing costs of road trauma in each LMIC.

The report highlights the road safety model of Victoria, Australia as a good example of a cooperative partnership which led to substantial road safety benefits. There were attempts to transfer the Victorian model of strong traffic law enforcement supported by high profile mass media publicity to KwaZulu-Natal (KZN) province in South Africa during the late 1990s. There was little effort to adapt the successful Victorian interventions to South African conditions and constraints. Perhaps the least effective (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 (and injury) fatalities 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 Bodinor, personal communication) 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 lack of involvement of road transport decision makers and development in local conditions to provide the background for the transfer of principles, and perhaps successful interventions, from an HIC. Partnerships, and shared responsibility for the road safety “system”, are key elements of Sweden’s “Vision Zero” strategy which is being seriously considered in HICs to guide their future directions. Perhaps many LMICs would find the ultimate goal of zero road trauma attainment of a realistic goal within their current resources. The target should not distract attention in either LMICs or HICs from the 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 uncritically, the report is an excellent overview of what has been effective in road safety in HICs. The report also provides the basis for fundamental 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.