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 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 was 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.7 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.8

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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”.9 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.10

Before the widespread adoption of soccer headgear makes it difficult to evaluate this latest sport injury preventive measure, next year 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.11,12 Nonetheless, no all new personal protective equipment is efficacious and effective.

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About safety and safety promotion concepts

We were very interested in the comments of Nilsen et al in the “concept of safety” that appeared in a recent issue of Injury Prevention.13 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 WHO Collaborating Center on Community Safety Promotion, Karolinska Institute), and is available in .pdf format on the Institut national de santé publique du Québec’s website, in English, at http://www.inspq.qc.ca/pdf/publications/150_SafetyPromotion.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.14

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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
this five chapters it gives in turn a compre-
prehensive catalogue of the funda-
mentals of road safety, the impact of road
trauma across the world, the key factors
contributing to crashes and consequen-
tial injury. These chapters then discuss
how LMICs need to really believe that the problem is prevent-
able, 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 sub-
stantial, but that early successes from HICs
are lost daily to road traffic collisions. While a
majority of LMICs have a huge public health
investment in local conditions to provide the back-
ground 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 interesting but it is ultimately an
analytic vision in which they do not currently
see a return on their investments. The target
should not be too late forLMICs to challenge
the unbridled growth in motorised transport, or
to at least give much higher priority to
managing exposure through land use policies
and transport strategies in general (for exam-
ple, separating road transport modes operat-
ing with disparate speeds and masses;
discouraging unnecessary trips; and encourag-
ing the use of safer and non-road travel
modes). LMICs 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 fully
recognising 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
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small. In this chapter we discuss how LMICs
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