Parent awareness and attitudes survey
From the Alberta SAFE KIDS Campaign, a report of a telephone interview survey with 276 parents of children under age 15. Surprisingly, perhaps, ‘accidents’ were viewed as the most worrisome risk to children — named by 44%. The other top five risks were: fire (29%), dental (12%), road (10%), and falling (8%). Altogether 71% of the 2609 homicides reported in 1993 were firearm related, and one third of the total involved 15–24 year olds. Also in this issue is a report on work related injuries and illnesses associated with child labor in 1993.

Insurance Institute for Highway Safety (IIHS) ‘Status Reports’

The May issue of this IIHS publication has a feature on side impact airbags, predicting that they will ‘be in lots of cars very soon’. It lists the manufacturers and models in which they intend to introduce these devices as standard equipment. Another feature deals with the poor enforcement of minimum purchasing age laws for alcohol in the US (Public Health Reports 110:4). Despite this, the report of a survey (Public Attitude Monitor 1995) shows strong support for zero tolerance laws and graduated licensing programs, as well as night time driving curfew laws, for those under 18 years. In a separate study by AF Williams et al., comparing data from high school students in 1980 with 1995, it appears use rates have increased but still remain too low, especially among teenage passengers. Most intriguing is the wide variation in driver belt use rates — from 36 to 91%, depending on the school surveyed. Finally, as should have been expected, after federal maximum speed limits were abolished, drivers are going faster and breaking the new speed limits on urban freeways.

LETTERS TO THE EDITOR

Third International Conference on Injury Prevention and Control

EDITOR.—The various comments concerning the Third International Conference on Injury Prevention and Control scattered throughout the second edition of Injury Prevention are appreciated by at least one organizer. While I am pleased that the hospitality aspects of the conference were considered worth the expense of attending a meeting so far away, my purpose in writing to you is to respond to comments about the program and to suggest a new paradigm for thinking about the conferences.

One of my most interesting tasks was to triage all abstracts for review. More than most, I was able to see the broad spectrum of the submitted abstracts. As I read, I saw our intentions to schedule only excellent and innovative papers some falling around our ears. The reason? A large proportion of submitted papers consisted of injury incidence surveys. Many had intervention randomization and a clear relation to the actual study, simply tacked onto the end. Others were program descriptive papers, many without rigorous evaluation. While our conference objective was clearly to encourage interdisciplinary understanding, we also wished to ensure the conference series continued to develop scientific rigor. In addition we acknowledged that program personnel at the coal face of injury prevention action are often poorly resourced and isolated; factors often resulting in less than optimal program evaluation. In the end fiscal pragmatism won out — we found a place in the program for all authors in the most creative way we could.

The question needs to be asked once again, ‘What do we want from international conferences?’ We know that health administrators look to conferences for evidence of ‘what works’. They want to take advantage of work undertaken by others in order to transfer what knowledge into their strategic plans. While this makes pragmatic sense, it is also illogical. Comments by Forjuoh and Zwi, highlight problems concerning the transferral of technology and prevention mechanisms from industrialised to low and middle income countries, point to the pitfalls of such pragmatism. There are similar difficulties involved in such transferance between industrialised high income countries, simply because the political and cultural differences are great. We need skills to take injury control principles and apply them to our own political and cultural environments. It may be that the notion of ‘what works’ is too simplistic a question to ask.

The fact being the case, what do we expect to get from international conferences? An occasion for debate? Professional training? Learning new skills? New ideas? For most of us all the above apply. The degree to which our expectations of the conference are met will relate directly to the commitment of the injury prevention community to assisting the development of rigour, and ensuring the establishment of realistic goals in program planning and evaluation, together with commitment to the professional development of new players in the field.

The international injury prevention community will reap what it sows — that many health administrators are reluctant to invest in sound evaluation of the injury prevention program they fund, and the result is beginning to show. We simply cannot continue to expect to benefit from the contribution of others without making a substantial contribution of our own. In addition, we can’t expect to receive cutting edge evidence from short term programs run on a shoe string budget.

The Melbourne conference experienced degrees of cooperation from session contributors. One North American delegate filled out his program by approaching the authors of the abstracts submitted by his colleagues who found they couldn’t attend at the last minute. He must have been exhausted by the end of the conference. His commitment to the work of colleagues and to the integrity of the conferences was something I will not forget. He was one of many. At the same time, while the meeting was attended by almost one thousand delegates, I was disappointed to see inexperienced researchers and program personnel presenting their papers to almost empty rooms. From where can they expect to receive helpful feedback on their research/program methods if not from those who have gone before? (Maybe it said more about the weather and tourism opportunities in Melbourne?)

I suggest that a change of mindset is required. If experienced practitioners focused more on what they could contribute to the conference, rather than what they could get out of it, we may see rapid development reflected in the conference contributions of such kind should be honoured. Maybe future conference organisers could consider ways in which this could be achieved.
The future for the development of injury control as a discipline is in our hands.

PAM ALBANY Conference Director, Injury Control Program, Grace Vaughan House, 227 Shubie Tea, Shannan Park, PO Box 8172, Perth Streeting, WA 6849, Australia


2 Zwi AB. Injury control in developing countries: context more than content is crucial [Disent]. Injury Prevention 1996; 2: 91-2.

Fractures caused by bicycling

EDITOR,—Following the recent National Bike Week, we would like to report some current findings of an ongoing study of causes of fractures in 0–16 year olds in Swansea, Neath, and Port Talbot. This is not intended to make a case against cycling for young people, but rather to point to the need for proper equipment and, most particularly, to the need for safety helmets and other bicycling gear.

For every person in the 0–16 age range receiving a new diagnosis of fracture of any bone during attendance at either of two accident and emergency departments information was sought regarding the location of the accident, activity at the time, and mechanism of the injury resulting in the fracture.

In the seven days Thursday 30 May to Wednesday 5 June, 61 new fractures were identified. The cause was known in 57 (93%) and 14 of the total (23%) were known to be due to bicycle accidents. Only one of these involved a car, which was stationary at the time. The injuries were fractures of the wrist, five; radius; one; elbow; two; hand; two; clavicle; one; mandible; one; nose, one; and parietal and frontal bones, one. Four children required admission to hospital.

Seven of the accidents occurred on the road, two on the pavement, one on rough ground, one on public grassland, one in a garden, and one location was unknown. These findings concur with those of Acton et al in Queensland, who found similar numbers of children injured in on-road and off-road sites, the commonest reason for injury being ‘faulty riding’.

Bicycle accidents are by far the largest cause of fractures in this age group in the week described. These fractures are the tip of an iceberg of accidental injury to children, and it is clear that a high percentage of these injuries are eminently preventable. Let us advocate the use of the bicycle — but make sure that we take our advocacy role further in seeking safe cycle routes, excellent cycling education, and support for cycling safety equipment.

ANN DELAHUNTY Public Health Medicine, Inthul Hergady Medicine, 41 High Street, Swansea SA1 1LT, UK

PAM NASH Accident and Emergency Department, Neath General Hospital, Neath, SW6 5BY

MICHAEL MCCABE HOWARD ALLEN Accident and Emergency Department, Morriston Hospital, Swansea SA6 6NL, UK


Bicycle helmet use

EDITOR,—The important findings reported by Sack B et al (1996) are strengthened by some of our own. We validated cyclists self-reported helmet use by comparing questionnaire responses to documentation of helmet use in emergency department records and found 96% positive and 96%, negative predictive values. Reported use seems to self report, at least of helmet use, are valid.

We also studied the relationship between helmet ownership, use, and age based on data from a recently completed National Candlestick Study of injured bicyclists treated in the emergency department or hospitalized at one of seven hospitals in the Seattle (USA) area between March 1992 and August 1994. The Regional trauma center and medical examiner’s office from two counties were included to ensure that serious injuries and deaths were included.

Riders were asked if they owned a bicycle helmet at the time of the crash (not necessarily involving a car collision) and if so, if they were wearing it when they crashed. Parents filled out a mailed questionnaire for children under 14 and subjects who did not respond by mail were interview by telephone. The response rate was 88% and showed that 76% of subjects owned helmets and 50–7%, reported wearing them at the time of the crash. Helmet use was recorded in the medical record for 52.5% of the subjects treated.

As shown in the table below the ratio of use to ownership varied by age; the highest rates were found in adult riders, the lowest in teenagers. If we assume that many of the adults are parents, this may help explain the unusually high rates of use found for children. These figures may also be high as a result of a 10 year multifaceted community wide campaign to increase helmet use in the Seattle area.

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Owned helmet</th>
<th>Wore helmet</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No in group</td>
<td>No in group</td>
</tr>
<tr>
<td>&lt;6</td>
<td>190 75-120 40 7 47</td>
<td></td>
</tr>
<tr>
<td>6-12</td>
<td>938 77 544 447</td>
<td></td>
</tr>
<tr>
<td>13-19</td>
<td>365 67 175 32 1</td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>781 75 607 59 0</td>
<td></td>
</tr>
<tr>
<td>&gt;30</td>
<td>300 86 272 78 2</td>
<td></td>
</tr>
</tbody>
</table>

All ages 2574 76 1718 50 7

Health advice to travellers

EDITOR,—An item often neglected in health advice given to travellers is the potential for injury. This seems quite extraordinary when one of the greatest threats, often the greatest threat, to the life and health of travellers, is injury. This applies particularly to younger travellers.

This neglect has been recognized in a distance learning Diploma in Travel Medicine course which is being run by the Department of Public Health and Department of Infection and Tropical Medicine at the University of Glasgow.

One of the problems of contributing to such a course is the paucity of published research in the literature. Here are my anecdotes and everyone has personal experience of the problems but it actually quite difficult to put together a structured series of lecture notes from which future diplomats may realistically advise their patients and what is trivial. Another problem is the wide variation of experience in different countries, some being far more hazardous than others.

In order to enhance my contribution to this diploma course, I would like to listen to any or all of you readers who have particularly experiences in this field and who might have material that I can use in my contribution to the course. Any material used will be acknowledged in the lecture notes issued to the diploma students.

GORDON AVERY Public Health Medicine, Isobel Morgenstern 41 High Street, Swansea SA1 1LT, UK

BOOK REVIEW


In 1994, Bernardo Rodriguez Jr, an 8 year old, for four stories to the apartment shaft of his apartment building at 140th Street near Cypress Avenue in the Mott Haven section of the South Bronx, New York. His body was discovered when blood was observed dripping from the ceiling of the elevator.

Was the death of this child the result of an unintentional injury? Was this death preventable? Is assessing blame in such a case possible or useful? Children in this unit of the Diego-Beekman Building played in the hallways because the neighborhood around their project was terrorized by drug dealers. Clearly, the boy was unengaged in a risky behavior; is the 8 year old to blam? Bernardo was being supervised that day by his grandmother, who was in the apartment; his mother was in jail. Do these women bear the guilt of the death? Families often feel that the elevator was frequently broken and that the door did not close properly. Should the city be held responsible? New York City had drastically reduced its public building inspection services as a cost-saving measure. In fact, the city ‘blamed’ the family. Is the problem inherent in our societal ‘systme’, rife as it is with economic injustice, racism, and prejudice?

The story of the death of Bernardo Rodriguez is part of the rich texture of Amazing Grace by Jonathan Kozol. The book provides a window into a world that few of us professionals have witnessed first hand. Coming up from the subway at the Brook Avenue station, with Kozol, we meet the children, their mothers and other relatives — mostly females because of their religious leaders, and a series of other characters that inhabit one of the most distressed and disadvantaged landscapes in America. We are moved by the power of the narrative to bring human lives to life. We feel the pain and the indignity of these children and their families. Kozol doesn’t make it easy for us. There is no list of problems nor facile solutions. This book is frustrating because there is no conclusion, no recipe for action. Those of us in the health