News from India and China

Morbidity and mortality due to injuries have been officially recognised as significant public health problems in the high income countries (HICs). However, this is not true for the low income countries (LICs). This lack of recognition is assumed by many to be because of an absence of data regarding injuries and because of the prevalence of a “fatalistic attitude” in the population of these countries. Both these assumptions are probably wrong. However, deaths due to injuries are clearly given a great deal of importance by the public and officials and these newspapers carry frequent editorials regarding the lack of safety in their respective countries. These newspapers also report the concern that citizens show by demanding safer roads, schools, and homes. This concern is expressed in the form of letters to the editor, formation of community groups to tackle the problem, and protest actions in response to tragic events. Some studies also report that poor people spend enormous amounts of money (as a proportion of their incomes) on the treatment of their injuries and other ailments.

This evidence clearly shows that injuries are recognised as a serious problem by society and that the citizens at large do not have a fatalistic attitude toward life. If they did, they would not end up spending so much to have their injuries treated. However, what is true is that LICs have not been able to institute effective programmes for injury control. This is largely because problems in LICs are very complex and there is little precedence for effective safety policies and interventions that suit low income societies. In addition, LICs also suffer from a lack of expertise and specialised institutions in the area of injury control. Unless local expertise is developed, promoting sustainable and effective injury programmes will be difficult. It appears that attempts are being made in some countries of Africa and Asia to move toward this goal of strengthening local expertise.

Mr Hua Yong Hong of the Traffic Management Research Institute of the People’s Republic of China organised a week long seminar on road traffic safety and congestion last October. The seminar was held in Hangzhou and attended by senior police officials representing the different provinces of China. The lecturers at the seminar included experts from China, Japan, and the USA. The police officers from different provinces made presentations on specific issues concerning traffic congestion and traffic accidents in their specific regions. With increases in motorisation, there are serious problems concerning pedestrians and bicyclists of which a large number constitute children. The conflict between the need for providing facilities for faster motorised traffic and ensuring the safety of vulnerable road users became evident in the discussions. At present there are clearly no clear guidelines for the resolution of these problems except the control of vehicular speeds through traffic calming and police enforcement. However, much more work needs to be done to evolve location specific designs and policies.

An International Course on Injury Control and Safety Promotion was held in the first week of December in Delhi, India. The week long course was organised by the Transportation Research and Injury Prevention Programme of the Indian Institute of Technology, Delhi, in collaboration with Department of Public Health Sciences, Karolinska Institute, Sweden. The course was sponsored by SIDA, Sweden, and WHO and attended by 26 participants from 11 countries. The faculty included Leif Svanström, Ragnar Andersson, and Karen Leander from the Karolinska Institute, Dinesh Mohan, Geetam Tiwari, Mathew Varghese, Iramana Qadred, and Rajesh Patel from IIT Delhi, and Larry Berger and Rick Smith from the USA.

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A funny thing happened on the way to the meeting: on guns and triggers

Two women who were attending the 1997 American Public Health Association (APHA) annual meeting in Indianapolis were shot in a restaurant while waiting to be seated. A man with a registered .32 caliber handgun was leaning over to pick something up from the floor when a weapon fell out of his pocket, dropped on the floor, and fired two bullets. In the gun world, this is known as a drop-fire, a close kin to a bump-fire, both due to defective trigger mechanisms. When a child chokes on a small ball, a toy rocket, a toy gun, the regulatory machinery of government is immediately engaged. No such scenario was set in motion by this shooting in Indianapolis. Although the Bureau of Alcohol Tobacco and Firearms regulates the sale and interstate commerce in handguns, it has virtually no authority to set standards for the design or safety of domestic handguns. And firearms are among the few products specifically excluded from the jurisdiction of the Consumer Product Safety Commission. This is despite the fact that guns are second only to automobiles as the consumer products most frequently responsible for death in the US.

Children under 15 years in the US are 12 times more likely to die from firearms than in 25 other developed countries and the rate of unintentional firearm injuries in this age group is nine times higher than in the comparison countries.1 A study of US handgun owners by the National Institute of Justice estimated that there are 65 million handguns in circulation in the US. This same study found that 55% of handgun owners keep their guns unlocked and 30% keep them unlocked and loaded.2 The deadly combination of accessible handguns and children is underscored by a recent study which found that 25% of 3–4 year olds and 70% of 5–6 year olds have the finger strength and coordination to fire most of the commonly available handguns in the US.3

There are a number of effective countermeasures to unintentional firearm injury to children. The most obvious, and the one recommended by the American Academy of Pediatrics, is to keep guns out of the home. Locked storage boxes for handguns and separate locked storage of ammunition are others. A properly designed safety lock, a device that prevents the trigger from moving without a key or other unlocking device, can also be an effective countermeasure. On 7 October 1997, President Clinton announced that eight major handgun manufacturers have agreed to provide child safety locks on all new handguns they sell by the end of 1998. While this is an important first step, the voluntary nature of the agreement, the application only to new handguns, and the lack of regulatory power over the design of the safety locks and the firearms themselves, raises the concern that this is a token action which will not translate into many young lives saved.

The two APHA participants survived, sustaining only minor injuries. Would that this were true of the 200 children killed unintentionally and the 800 children intentionally killed by guns in the US each year.

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Injuries to young men in Australia

The National Health and Medical Research Council has released a major study Unintentional Injury in Young Males, 15 to 29 Years.1 The terms of reference of the working group were to undertake a review of available data and contributory factors and to identify, review, and assess means of prevention. The report sets out the size and nature of the injury problem; the influences on injury, such as sociocultural factors, alcohol, risk behaviour; countermeasures; policies for youth and injury; and recommendations.

The problem

1. Young men have four times the rate of injury death and three times the rate of hospitalisation as young women the same age.
2. Injury is responsible for 1600 deaths and 60 000 hospitalisations among these young men each year; death rates for all injuries are 7.7 per 100 000 and unintentional injury death 47.7 per 100 000;
3. Transportation is the leading cause of death (34.5 per 100 000), pharmaceuticals poisoning is next (3.2 per 100 000, one tenth the rate), with drowning close behind (3 per 100 000);
4. Hospitalisations are caused by transport injury (rate of 684.5 per 100 000), falls (144.8), sport and pharmaceutical poisoning (140.7);
5. The leading causes of presentation to emergency department for injury are occupational injury and sports related injury;
6. Those with higher injury risk rates are those in rural and remote areas, Aborigines, and Torres Strait Islanders, and those in certain occupations such as farm workers, factory hands, plant operators.
Females than non-Maori females, higher
10000. Suicide is higher among Maori
20–24 years 55.7, and total 15–24, 45.4 per
was marked in young men aged 15–19 years
130 per year) of the preceding years. The rise
in itself was up on the stable figures (125 to
1996. It is noted that important questions of
which current evidence is inadequate.
Conclusions
The report identifies a range of interventions
that can be put in place, research and evalua-
tion that needs to be undertaken, key policy
and structural issues requiring attention, and
the need for further development of preven-
tion oriented surveillance of injury.
It is noted that important questions of how
to address the issue of injury among young
males remain to be answered and the need to
work systematically to deal with research,
implementation, and decision making infra-
structure is stressed.

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Youth suicide in New Zealand
There has been considerable concern in New
Zealand in recent times over a jump in the
suicide rate for young people in the 15–24 age
group. The 1995 figure of 156 deaths recorded
was a rise over the 137 in 1994, which in itself
was up on the stable figures (125 to 130 per
year) of the preceding years. The rise
was marked in young men aged 15–19 years
and among women 15–24 years.

The age specific suicide rates in 1995 were:
males 15–19 years 34.5 per 100,000; males
20–24 years 55.7, and total 15–24, 45.4 per
100,000. The figures for females were,
respectively, 11.1, 14.6, and 12.9 per
100,000. Suicide rate is higher among non-Maori
females, higher
among Maori males 15–19 and lower among
those aged 20–24 years.
The rise in suicides was the subject of
much public discussion and lead to the
formation of Youth Suicide Prevention Strat-
egy, the introduction of a new mental health
awareness curriculum in schools.
In the past the law had limited publication
to name, address, and occupation. Since
1996 coroners have had discretion over the
details permitted to be published concerning
suicide, but this power is rarely used. Follow-
ing a number of suicides some coroners have
suggested that the practice should change
because the right of the public to know and
the usefulness of research outweigh the right
of the grieving family to privacy.

David Chalmers
Injury Prevention Research Unit, University of Otago,
Dunedin, New Zealand

Safe medicines campaign in Glasgow
Greater Glasgow Health Board, the statutory
organisation responsible for commissioning
health services in Scotland’s largest city,
became increasingly uneasy in 1997 at the
rising tide of hospital admissions of children
who had ingested medicines. In response,
they launched an end of the year awareness
raising campaign in conjunction with the Royal
Pharmaceutical Society of Great Britain. The
initiative aimed to focus the dangers to chil-
dren, particularly those under 5, of accidental
poisoning and to promote the safe storage of
medicines at home. A key message was that
all children, regardless of social background,
are potentially at risk. A packed press confer-
ence in November heard the head pharmacist
of the Royal Hospital for sick Children,
Yorkhill, sheepishly confess that his own pre-
school child had found and swallowed some
paracetamol tablets!
The campaign received widespread expo-
sure in the local media, though its impact on
the incidence of ingestions remains to be
assessed. Health promotion and public rela-
tions experts drew their background informa-
tion from a number of sources including the
recently established Yorkhill version of
Canadian Hospitals Injury Reporting and
Prevention Program (CHIRPP). CHIRPP
was able to confirm a real rise in children
presenting to the accident and emergency
department with ingestions rather than sim-
elly an increasing tendency of clinicians to
admit such children to the inpatient wards.
CHIRPP will also doubtless prove an invaluable
means of evaluating the success of the campaig
This has yet again highlighted the crucial
importance of having an efficient local
injury surveillance on hand to provide appro-
appropriate information to safety professionals.

David Stone
The PEACH Unit, Department of Child Health,
Yorkhill Hospital, Glasgow G3 8SJ, UK

Southern Africa report
One aspects of paediatric trauma medicine
that really appealed to me when I entered this
field just over 10 years ago, was the challenge
of non-operative management of blunt inju-
ries. Like most colleagues, I certainly have had
no deep aversion to the blood spattered, adrena-
line rich milieu of emergency surgery, but
when working in adult trauma units, I had
found the endless routine of operating on vic-
tims of gunshot and knife attacks both
predictable and depressing. At Red Cross
Children’s Hospital, my happy experience has
been to deal mostly with blunt injuries, usually
the result of falls or traffic collisions, and
where clinical diagnostic ability and the art of multi-
disciplinary management are more important
than speed of surgical delivery. In fact, in weeks
and in spite of government efforts to control handgun ownership (as outlined in my last report), I have had no choice but to dust
off my scalpel, don the bloodproof apparel
known as “universal precautions”, and spend
long hours in the operating room repairing the
ugly damage caused by flying bullets—always
uglier when it lacerates the flesh of young chil-
dren. In preparation for this summer holiday
season, I have restocked my unit with large
bore chest drain catheters, high flow
intravenous infusion sets, instrument packs
for resuscitative thoracotomy, and an autotransfu-
sion device—all of which I have found myself
behind years ago at the adult hospitals where
knife and gunshot wounds are pretty much
stock-in-trade. With heavy hearts, my staff and
I roll out the red carpet for a new problem in
the field of childhood injury—while our initia-
tives still struggle to make an impression
on the old ones.
The official South African figures for road
traffic injury in 1997 are horrifying: 517 669
collisions, 22 757 serious injuries, and
9 146 deaths. Against this doom and gloom, the
“Alive Arrive” traffic safety campaign launched
acrossPIAOUTHAFRICA

PEDNET
A recurring theme among pedestrian advoca-
tes is the lack of anger at pedestrian
injuries, and the tendency to blame the
victim, especially children, for their injuries.

Pedestrian Injury/Pedestrian Injury
Prevention
1306.11; 2701, South Africa

Injury Prevention 1998;4:78

Injury Prevention
1998;4:78
Sally Flocks reported on a 4 year old killed on an Atlanta residential street. The child was struck by a police officer speeding at 45 mph for no apparent reason. (The officer has been charged with vehicular homicide.) Two years ago, the neighborhood requested traffic calming for that particular street but the City turned them down. Curiously, the mayor said at the funeral “in many ways, this is the worst kind of tragedy, because we have no one to be angry with”. Sally said that before the mayor’s comment, she had two places to target her anger, but now she has three. Mike Mott suggested a fourth target for Sally’s anger—“NHTSA”, that spends millions to protect those inside a vehicle and nothing to protect those outside the vehicle.”

While that comment may be a slight exaggeration, the US government policy toward child pedestrian injuries appears to focus on altering the child’s behavior. PEDNETers point to “motorist focus, not the child, is the party going too fast for the situation.” Yet in injury control efforts, both are legal disinterested parties would recognize that the motorist traverses the street. Both are legal classified “bicyclerelated”. In both bases, the classification of motor vehicle injuries separated by the activity of the victim seems unique. Itshardtoimagine gunfireinjuries separatedbythevictim. (Itshard too classify injuryprevention. Child pedestrian deaths during Halloween—United States, 1975-1976. MMWR Mot Mortal Wty Rep 1997;46:987–90.)

LETTER TO THE EDITOR

Fatal and non-fatal farm injuries

Eston, -- In a recent issue of Injury Preven-
tion, in an article on fatal and non-fatal farm injuries, the organization Farm Safety 4 Just Kids is mentioned as an example of a grassroots group working on children’s farm safety. Dr Rivara is a fine researcher, and has worked with Farm Safety 4 Just Kids on other analyses, and we are glad that you published his article.

The board of directors of Farm Safety 4 Just Kids, however, asks to be placed on record with your journal to explain the last phrase in paragraph 2 of the introduction: “Grassroots groups, such as Farm Safety 4 Just Kids, have been formed to increase public awareness of the magnitude of the problem, conduct public education, and lobby for legislation and regulation”. Lobbying for legislation and regulation is an activity that, while not prohibited by our non-profit 501 c3 status, has not been a major component of our work. The Farm Safety 4 Just Kids board of directors has been sensitive to the variety of mixed reactions and opinions there are to such activities as legislation and regulation by an organization that is working directly with farm families.

Thank you for allowing us to further explain our organization in addition to the information included by Dr Rivara.

MARTHA S CLINE
Executive Director, Farm Safety 4 Just Kids, 110 South Chestnut Avenue, Eartham, LA 90072, USA


BOOK REVIEWS


This book challenges the widely held views in road safety that young children are biologically incapable of coping with the road environment, until an appropriate stage of psychological development is reached. It thus provides an informative framework for a debate on the aims and objectives of road safety education and usefully contributes to the debate on the relative role of education, engineering, and urban planning methods in injury prevention.

The report was commissioned by the Department of Transport from a team of developmental psychologists at the University of Strathclyde, Glasgow, Scotland. The first author, James Thomson has been actively involved in the development and evaluation of both experimental and operational road safety programmes, but the report ranks widely than the authors’ own programmes.

The book comprises five main sections: (1) aims and objectives of road safety education, (2) current methods employed in road safety education, (3) theories relating to child development, (4) implications of these theories for training, and (5) conclusions and recommendations. A clear and concise executive summary is provided and useful summary sections for each chapter. The bibliography of 220 references draws widely from the field of development psychology. One criticism here is that more attention is given to the road safety literature from Europe than from the USA or Australia. The report, however, usefully summarises the developmental psychologist perspective on this issue, is (thankfully) free from jargon, and very clearly written. It provides a good source of some scholarship and careful argument.

The aims and objectives of current road safety education are explored in chapter 1. What emerges is the lack of concrete objectives in most programmes. Even when more precise objectives are defined, the majority are concerned with knowledge and attitude change, rather than behaviour. As there are no direct links between knowledge changes and behaviour, the validity of road safety education can be questioned. The authors go on to analyse different components of the complex pedestrian task: detecting the presence of traffic, making visual timing judgments, coordinating information from different directions, and coordinating perception and action. They discuss how such skills develop in children and the levels of skills that can be expected in children of different ages. They cite convincing evidence that children’s performance on a range of clearly defined pedestrian skills can be accelerated, providing appropriate training is given.

The issue of appropriate training is examined in chapter 2. A useful distinction is made between the content of a programme and the methods employed: programmes can fail if the content is inappropriate and/or if the methods are inappropriate. What methods have been used in this field? Classroom based verbal methods, books and printed materials, films and videos, and practical training are all analysed. An interesting observation is that video techniques can offer greater flexibility than films, particularly if they are tailored to children’s own locality and incorporate children as subjects. The feedback capabilities of such local videos may be worth exploring further. But the report particularly favours the use of practical skills training, involving
active behavioural participation and their arguments is convincing. “Skiing or swimming, driving or learning to ride a bike all require practical experience: no-one has ever learned to do these things just sitting at a desk. Yet this is precisely how we expect young children to cross the road” (p 59).

Chapter 3 provides the theoretical underpinning of why practical skills training is effective, concentrating in particular on the theories of J J Gibson, Jean Piaget, and L S Vygotsky. Skills and strategies cannot be taught solely by verbal means but need to be built up from their constituent behaviours. There is strong evidence that learning is more flexible than earlier supposed, particularly when appropriate interventions are employed and the authors conclude that appropriate training could begin as early as 4 years of age.

The implications of child development theory for training are discussed in chapter 4, with peer tutoring, adult led training, and peer collaboration being considered. The first two of these methods stem from a Vygotskian approach and are likely to be best suited to the teaching of skills; and strategies. Peer collaboration, on the other hand, is more in line with Piagetian theory and would appear to be more useful in the provision of conceptual understanding. The authors believe that successful training needs to include both approaches.

The final chapter summarises the context of the report and produces a range of recommendations for both practical training and for future research.

One reservation about the report is that it is not overtly systematic: it does not set out its criteria for the way its evidence was obtained nor its inclusion criteria for how studies were selected. Is there a literature that does not support the conclusions, which has not been cited. It would have been useful to have had the study findings summarised in accompanying tables.

Childhood injury prevention requires input from a wide range of disciplines and this contribution from the developmental psychology field is a useful addition to the literature, particularly when it is attempted to provide a more theoretical base to the subject. Attention to the nature of the messages, more precise objectives, and the use of appropriate methods are important when we consider the wider debate on the role of education in injury prevention. Pessimism about the limitations of education may not be wholly justified if we design more appropriate educational interventions.
innumerate (as, incredibly, Greenhalgh herself professes to be!).

Several of the chapters that follow are variations on these themes. The chapter on drug

injuries (as, incredibly, Greenhalgh her-

tongue-in-cheek boxes; one listing “Ten tips for the pharmaceutical industry on how to present their products in the best light”. Apart from this bit of amusement, however, this chapter offers little more that is relevant for most readers of the book “The International Society for Child and Adolescent Injury Prevention (ISCAIP)”. ISCAIP invites you to attend a one day conference, the 3rd ISCAIP Conference on Childhood Injury following the 4th International Conference on Injury Prevention and Control:

RAI Conference Centre, Amsterdam, The Netherlands

Thursday, 21 May 1998, 9:30 am–5:00 pm

The program will focus attention on childhood injury in Europe, child occupant protection, and making regulation work. In addition, a debate on intentional injury and ISCAIP is scheduled for the final plenary. We are also offering the opportunity for registrants to submit commentaries to be included in the conference discussions.

Attendance fee: £55 ISCAIP members; £75 non-ISCAIP members

If you would like to receive further information and a registration form, please fax or e-mail Angela Seay, ISCAIP Administrator, c/o CAPT, 18–20 Farrington Lane, London EC1R 3AU, UK (tel: +44 171 608 3674, e-mail: Aseay@compuserve.com).


6–13 December 1998. International Course on Prevention and Control of Road Traffic Accidents and Injuries, New Delhi, India. The course is being organised by Indian Society for Child and Adolescent Injury Prevention (ISCAIP), New Delhi, India. Further details: Conference Secretariat ICCHE ’98, c/o VVAA Conference Services, PO Box 8153, 3503 RD Utrecht, The Netherlands (fax: +31 30 247 4647, e-mail: congress@vvaa.nl).

Methods


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Traffic
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Home


School


Burns and scalds


Drowning


Sports and recreation


Poisoning and ingestions


Occupational


Violence and suicide


