Better late than ever: confronting Greece’s major health problem

It is frequently said that neither individuals nor nations can learn from the experience of others—they have to pay their own price before they recognize a problem and master their resources to confront it. Motor vehicle accidents have become major epidemics in most western countries before measures were successfully implemented to reduce the burden of death, disability, and unhappiness generated by these injuries. In Greece, mortality from motor vehicle accidents increased from 11 per 100,000 persons in the 60s to more than 23 per 100,000 persons in the late 90s, when Greece was competing with Portugal for the unenviable position of the late 90s, when Greece was competing for the unenviable position of the country with the highest mortality from motor vehicle accidents generated by these injuries. In Greece, accidents have become major epidemics in the 90s, however, it has become apparent to most people and political leaders that injuries in general, and motor vehicle injuries in particular, constitute the number one health problem for Greece, a country that has been blessed with very low mortality from cardiovascular diseases and most forms of cancer. In 1991 several influential public health officials argued that the human factors were just as important as the poor road infrastructure in the web of causation of motor vehicle accidents. As a result the Center of Research and Prevention for Injuries among the Young (CEREPRI) was established.

In 1997 CEREPRI took coordinating responsibility for a nationwide campaign to highlight the importance of road traffic accidents as a public health problem. Specifically, the campaign, that was supported by the Division General for Transportation (DG 7) of the European Commission and the European Transport Safety Council, targeted seat belt use and two other cost-effective measures in reducing motor vehicle mortality. The campaign was one of the largest ever launched in Greece, since the antimalaria campaign in the early 50s and the vaccination campaign in the 60s. The results were carefully evaluated and, although the resources available to the campaign organizers were limited, it was effective in increasing seat belt use. Details about the organization and evaluation of this program project are awaiting publication in the American Journal of Public Health and further analysis focusing on specific components of the campaign are currently under examination. An unexpected, but welcome, consequence was that several individuals and organizations who were key contributors in the broad “Coalition for Life” that launched the CEREPRI coordinated campaign was subsequently independently energized in their own fields of specific responsibility, competence, or expertise. Thus, injuries in general and motor vehicle injuries in particular are now widely recognized as a health priority in Greece allowing some optimism that the beginning of the new century will coincide with the long delayed turning point in the increasing secular trend of motor vehicle mortality.

It is worth mentioning the positive role of the mass media, legislative initiatives, including among others upgrading the seriousness of non-compliance with mandatory seat belt use and substantial increase in the respective fine, intensification of enforcement of seat belt law, and a movement towards introducing road traffic education in the school curriculum.

In 1991, the WHO/CHIP program was created to promote the use of bicycle and motorcycle helmets world wide. By promoting helmet use, the helmet initiative will ultimately reduce the number of head injuries from cycle crashes. It serves to stimulate public health agencies to address injury control issues and to promote effective interventions. The WHO/CHIP program is based at the Center for Injury Control of the Rollins School of Public Health, Emory University located in Atlanta, Georgia. The initiative has adopted four strategies to promote universal helmet use. These strategies are complementary and were chosen as key collaborative elements in the world program. (1) Collect and distribute better data. (2) Develop a generic program to promote the use of helmets. (3) Evaluate legislative approaches to assist in the promotion of helmets. (4) Encourage international collaboration for the promotion of helmets. The WHO/CHIP program maintains a library of helmet resource information on the internet through the world wide web. An international network of helmet promotion programs is being established to expand and strengthen world-wide helmet promotion activities. Cooperating CHIP centres of excellence are chosen by the WHO/CHIP program (based on the application by the centre) in recognition of their efforts to promote and heterosexuals and their ability to serve others as a resource for information on helmet promotion.

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News from Australia and New Zealand

More Safe Communities and a communities conference

New Zealand and Australia have significantly increased their representation of communities and centres affiliated with the WHO Safe Communities. In 1999 the New Zealand Communities of Waitakere and Waimakariri and the Australian Communities SHOROC and Ryde have been indcuted into the movement and the Royal Children’s Hospital Child Safety Centre (Melbourne) has been inducted as a Safe Community Affiliated Support Centre.

The details of the programs that were the basis of acceptance as Safe Communities are available from the secretariat, which is based at the Department of Public Health Sciences in the Karolinska Institute, Stockholm, Sweden (www.ki.se).

The Waitakere Community, a city within Auckland, was inducted at a ceremony conducted as part of the Community Safety Conference, Pacific Rim 1999. The conference was a great success, not least because Waitakere City is a diverse community with very strong links to Maori and Pacific Islander communities.

Associated with the conference was meeting in which New Zealand colleagues continued their efforts towards the development of a network of people and organisations interested in injury prevention. At the time of writing it is hoped that the network will be established in the second half of 1999.

Efforts to increase cross-Tasman cooperation

Following the Pacific Rim conference there have been conscious efforts to increase the linkage between New Zealand and Australian injury prevention groups and individuals. The Australian Injury Prevention Network has established a liaison group for poster exchange. Suggestions as to how this might be done are most welcome. Current efforts centre on ensuring that information is shared; for example, Injury Network minutes and documents are to be cross-posted, web sites are being asked to cross link and so forth.

Details of the Australian Network, including a strategic plan, can be found at www.nisu.flinders.edu.au or by writing to the Secretariat c/o Child Safety Centre, Royal Children’s Hospital, Flemington Road, Parkville, Victoria 3052, Australia.

Australian National Injury Prevention Conference

The Third National Injury Prevention Conference was conducted in Brisbane in May and held by all to be a resounding success. The conference, under the title “The Challenge of Integration” broke new ground by being co-hosted by centres for accident research and road safety and for research on disability and rehabilitation medicine. The Australian Injury Prevention Network ran the conference with principal sponsorship provided by the national Department of Health. With 28 presentations and 500
Injury Prevention

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Conference in the year 2000.

Network is actively seeking ways to cater for

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delegates, about 50 of whom were inter-
national visitors, the conference generated

what convenor, Professor Rod McClure, called a “buzz” of excitement.

Noting the challenge to do better in presenting conferences that John Langley wrote about in his December 1998 editorial there were some interesting points about administration. Specific time set aside for posters with brief presentations by authors worked extremely well. Extra effort to support technical equipment ensured that sessions ran well and attracted strong positive comment.

The profile of delegates has varied between injury conferences. The previous conference, also a success, specifically attracted and catered for grassroots practitioners, with low costs and specific sessions. The Injury Network is actively seeking ways to cater for both researchers and practitioners in the next conference in the year 2000.

Compensation to victims for governments’ failure to act?

One of the papers at the Australian conference followed directly from a Barry Pless editorial in Injury Prevention. In the September 1998 issue, Barry used legal cases where governments were held accountable to victims for their failure to act on hepatitis C and were made to pay compensation, to ask why this is not occurring in relation to preventable injuries. This editorial inspired quite some discussion and the NSW Council acted by seeking out an interested lawyer to consider exactly this issue in a paper to the injury conference.

In the Australian context it is usual for “regulatory impact statements” to be prepared before the introduction of any regulation and these usually encompass some form of cost benefit analysis. The Chair of the NSW Council, Craig Patterson, together with fellow lawyer Louise Sinclair and Pam Albany from NSW Health wrote a paper exploring whether, and how, potential legal liability should be taken into account when these regulatory impact statements are prepared. Details will have to wait for the published paper but the interest was intense and the discussion vigorous.

More on the cost of injury in Australia

In 1997 the Victorian Department of Health funded the Monash University Accident Research Centre to estimate the lifetime cost of injury to the Victorian community. The work included estimates of the direct costs of care and indirect costs and was published as Report 124 from the centre. Using this work, Jerry Molle has since estimated the cost of injury for Australia as a whole and these tables are available from the Centre for Injury Studies at Flinders University, Adelaide (incorporating the National Injury Surveillance Unit, NISU). The Monash study can be found at www.general.monash.edu.au/muarc and the NISU tables at: www.nisu.flaunders.edu.au.

INJURY TO MAORI: DOES IT REALLY HAVE TO BE LIKE THIS?

Injury Prevention: Meeting

I A N S C O T T

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update on indigenous injury

Two new pieces of work illustrating both the creativity of Maori researchers and the cultural sensitivity in writing the report is intended to draw attention to the statistics in a meaningful, human way. Copies of the report can be obtained from Injury Prevention Unit, ACC, PO Box 242, Wellington, New Zealand.

The second report is a Study of Injury in Cape York Communities. Cape York is the northern peninsula in eastern Australia and the report covers the means used to document injury in five small remote communities. It shows how a range of information gathering techniques can provide a profile of injury that compliments existing data. The report can be obtained through the NISU in Adelaide (www.nisu.flaunders.edu.au).

Criminal liability and intoxication

In 1997 Australia was enlivened by the public debate that followed the acquittal of a well known football player on charges of assaulting two women on the grounds that he was too drunk to be responsible, that he was too drunk to know what he was doing, and could therefore not form the intention of committing assault.

The Federal Attorney General urged his state counterparts to “do something” about the so-called drunk’s defence. The Law Reform Committee of the Victorian Parliament undertook a detailed examination of the issue and has released a report entitled Criminal Liability for Self-Induced Intoxication. The committee’s recommendation is that evidence of self induced intoxication should continue to be used in determining questions of criminal intent and “voluntariness”. The committee Chair, and most of those that gave submissions to the review, is of the view that the problem is not one of law but of poor decision making and that the magistrate’s decision in dismissing the charge against the football player was in error.

As a solution to what they see as a justified public concern over this matter they suggest that in all serious offences, the “defence” of self induced intoxication must be heard before a judge and jury. The idea being that a defendant must convince a jury. The full report can be obtained from the Law Reform Committee, Level 8, 35 Spring Street, Melbourne 3000, Australia or downloaded from www.lawreform.org.au.

LETTER TO THE EDITOR


Christoffel and Gallagher have written this new book for a very specific audience—practitioners of injury prevention, particularly those working in public health agencies at the state and local levels. The content and style draw on the enormous experience of the two authors as practitioners and scholars in the field of injury. The work updates and advances the approach taken by the National Committee on Injury Prevention and Control in its “blue book,” Injury Prevention: Meeting
Another review of this book will appear in a later issue.


The main part of this excellent book is based on the experience of the National Poisons Information Service, London, and consists of 78 chapters on poisonous drugs or chemicals, or groups of substances. Plants, fungi, and snakes are also included. Each chapter is similarly structured, with key points of presentation and management, followed by a description of the substance and its use, its toxicity, clinical effects and case reports, treatment, and references etc. There are 29 very clear pictures of poisonous plants and berries and a surprisingly long list of non-venomous snakes. Not being a toxicologist, I cannot comment on the completeness or accuracy of the information given in this main section, but the expertise of the various authors would appear to guarantee that the information given is comprehensive and practical as well as correct.

The initial chapter of this book looks more generally at aspects of poisoning. There is a detailed chapter on risk assessment and management of the poisoned child, with a list of clinical effects (for example, arrhythmias) and the agents that may cause them and also a guide to the paediatric doses of common agents used in the treatment of poisoning. The pros and cons of the major methods of management are examined—emesis and gastric lavage, whole bowel irrigation, together with the use of syrup of ipecac and activated charcoal. This is an excellent chapter.

There is also a chapter on the epidemiology of poisoning. Considering that the book is presumably for use in the USA and Canada and presumably Europe and elsewhere, perhaps more details could have been given of the incidence of the different types of poisons in these different countries, though the relative important inquiries to the UK and USA poisons centres are mentioned.

The third chapter relates to the prevention of poisoning. Here again, the different approaches to the legislation on child resistant packaging in the different countries could have been mentioned, and there is no discussion on the current controversy on the use of reclosable child resistant containers compared with non-reclosables (strip and blister packs). The difficulties of carrying out and evaluating community programmes and of the education of individuals is rightly stressed.

Altogether a very useful, high quality, and well produced book.