REGIONAL REPORTS

Consumer activism pays big dividends in USA

Homer said that "The mark of wisdom is to read airtight the present, and to march with the occasion." In this regional report from the US, I commend those businesses and media outlets in America who have had the wisdom to listen to the concerns of injury prevention advocates and to either voluntarily withdraw their questionable products from the market and/or to change their advertising strategies. A few examples from various injury risk areas follow.

Newsweek (chooking prevention)

In spring of 1997, Newsweek published a special edition entitled, "Your Child From Birth to Three". One chart called "Building Health Habits" contained a serious error. It said that 5 month old babies could hand feed themselves zwieback or raw carrot chunks—a clear choking hazard for young children. In response to the concerns of the safety community, Newsweek published a correction in a subsequent issue, promising to send corrected versions of the early child-hood issue to newstands, hospitals, and doctors' offices. Any subscriber who wanted a corrected version of the chart was invited to call a toll-free number.

Mattel (toy safety)

In 1996, Mattel introduced the Cabbage Patch Snacktime Kids who were supposed to munch on plastic cookies and French fries. About 500,000 dolls were sold. In response to media reports that the snacking doll preferred to eat children's hair and fingers, Mattel pulled the dolls off the toy store shelves, ordering retailers to return any unsold dolls and offering $40 refunds to any dissatisfied consumers who had bought the dolls.

Haggard pants (fire prevention)

In 1997, Haggart Clothing Manufacturers produced a commercial in which a man re-enters a burning building to retrieve his pants. Upon seeing this ad, a New York fire chief called Haggart to complain that the fire safety community spends considerable time and energy trying to teach the public to "get out and stay out" of a burning building (personal communication). The fire chief alerted the National Fire Protection Association as well, and working together, they convinced Haggart to pull the ad immediately.

Northwest Airlines (drowning prevention)

On 26 April 1997, USA Today published a Northwest Airlines ad which depicted a child бouncing with his head in a five gallon bucket. The copy read, "Great summer savings on Northwest Airlines. Looking for a new vacation spot?" Ann Brown of the US Consumer Product Safety Commission called the Chief Executive Officer of Northwest and he agreed to pull the ad immediately. As a result, the ad ran only once anywhere—in that issue of USA Today. In addition Northwest published an article on hidden hazards in the home in its September 1997 in-flight magazine, World Traveler. Unfortunately, the same stock photo ran again in an advertisement for Nature's Solutions herbal supplements in the February 1999 issue of Parenting. The editor printed an apology in a later issue, stating that "we regret that the picture slipped through our normally stringent ad review process. Nature's Solutions has stopped using the ad, and has appointed a child safety advocate to review all of its promotional and advertising materials."

My thesis is that any single one of us in the injury prevention community can make a difference in influencing corporate America. Taking five minutes to communicate our concerns about a new product or its promotion in writing or by telephone is no little thing, but rather can produce tremendous results in the safety arena. As Ralph Waldo Emerson said, "Sometimes when I consider what tremendous contrivances come from little things—a chance word, a tap on the shoulder, or a penny dropped on a newstand—I am tempted to think there are no little things."

ANGELA D MICKALIDE
National SAFE KIDS Campaign,
1301 Pennsylvania Avenue, NW,
Washington, DC 20004, USA
tel: +1 202 662 0900, fax: +1 202 393 5722,
e-mail: amicka@aidsafe.org

Children in cars

It is still possible to buy child restraints to the now out of date European regulation R44.02 in Portugal, mainly old models from Portuguese manufacturers. APSI has been undertaking regular surveys of the way children are carried in cars. The most recent was in June 1999, and although the number of children properly restrained is slowly rising, it is still very low—only 21% of children under 12 are properly restrained. For children aged 3 years and under, half of the children were restrained although the observers, who were checking from outside the vehicle, reported that one third of these are obviously misused. The main errors noted were infant seats facing forward, infant seats lying on the car seat without being restrained, children unrestrained while the seat is restrained, and children restrained in an unrestrained seat!

Accident prevention in Portugal's health strategies

The Ministry of Health has published the Strategies for Health including targets for a reduction by 2007 of 30% in road crash deaths and a reduction in injuries at home and school and during leisure activities. The targets for 2002 include a fall by 15% of the road accident mortality rate by raising of restraint use, legislation for safe school bus transportation, compulsory use of cycle helmet and other issues related to cycling.

HELENA MENEZES
APSI, Vila Elsa, 7-RC Esp,
P-1100 Lisbon, Portugal
tel: +351 1 887 0161, fax: +351 1 888 1600,
e-mail: apsi@mail.telepac.pt

Injury surveillance in Northern Ireland

A recent development in Northern Ireland shows much promise for injury control in the province. A new electronic injury surveillance system has been introduced at the Royal Belfast Hospital for Sick Children, our only paediatric hospital. Information on the cause of injury is being collected on all children presenting to the accident and emergency department. The first six months' data has been examined for completeness and accuracy.
BOOK REVIEW


This book comes with a comment form so that readers can evaluate its worth. I found this a very useful starting point when reviewing the text and would encourage everyone else to use it too. As a researcher and practitioner who has had experience of evaluating injury prevention programmes, I was interested to see what this United States text has to offer, and how applicable it is to the UK.

The purpose of the book is to help those working in injury prevention understand (1) why evaluation is worth the resources and effort involved, (2) how evaluation is conducted, and (3) how to incorporate evaluation into programmes.

The book is divided into three main sections as outlined above. Section one is brief but covers important issues such as why evaluate, what components go into good evaluation, who should conduct evaluations and what type of information evaluation will provide. In general the content of this section is good, however it is not always easy to follow as it often refers to pages further on in the book. The least useful element of this section (for me) is the part that looks at “choosing the evaluator”. I believe most people reading this book will be doing so because they themselves will be carrying out an evaluation, or teaching others how to evaluate—not hiring an evaluation consultant.

Section two describes each of the four stages of evaluation: formative, process, outcome and outcome evaluation. I felt the most appropriate time to carry out each stage. There is a wealth of valuable, important, and relevant information in this section, particularly the comprehensive descriptions of each of the stages of evaluation. It is ideal as a reminder, and for anyone who is not clear about different types of evaluation and why each method is appropriate at different stages of a programme.

The methods for conducting evaluation that will help any reader carry out simple evaluation are dealt with in section three. Again, this section contains comprehensive and valuable information on various qualitative and quantitative methods that could be used to evaluate programmes. It is also encouraging to see that both the qualitative and quantitative methods are given equal importance. The quality of the information in this section is well balanced and is perhaps most appropriate for personnel who are not that familiar with evaluation methods. Any more detail would deter a beginner from ever evaluating anything! One of the least useful parts of this section is the idea of including information on how to communicate with, hire, and supervise evaluation consultants. This may be more relevant to a US situation but have less application in other cultural contexts.

The appendices contain basic samples of “questions to ask, events to observe, and who or what to count” during evaluation and the ideas included being based on injury prevention programmes the CDC currently fund. Although most injury prevention programmes worldwide would most likely fit into one of their 12 categories, I feel that this is not appropriate for an international audience. Appendix C contains a comprehensive and well structured checklist of tasks that can be used for reference. Appendix E, the glossary, is absolutely essential for anyone starting out in the evaluation of unintentional injury prevention programmes, and appendix D contains a basic bibliography.

On the whole I think this is a good resource for practitioners in the field of injury prevention. I do feel, however, that the book tries to cater for too wide an audience—for those with little or no experience of evaluation, to those who will use it as a teaching tool. The quality of the information that comes from being very useful and relevant, to extremely basic and perhaps a little condescending to the reader. Despite these criticisms I would definitely recommend this book to practitioners for personal reference. I would suggest, however, that it would be best used as a teaching resource for injury prevention coordinators who are training others in programme evaluation.
Advance notice

The full text of the Haddon Memorial Lecture, presented in New Delhi at the Fifth World Conference on Injury Prevention and Control by James Heddle this month, will appear in the June issue.

CALENDAR

MPH Course in Safety Promotion
15–26 May 2000, Stockholm, Sweden. Further information: Moa Sundström, Karolinska Institutet, Department of Public Health Sciences, Division of Social Medicine, Norrbacka, 2nd Floor, SE-171 76 Stockholm, Sweden (fax: +46 8 33 46 93, e-mail: moa.sundstrom@socmed.sll.se).

11th International Conference on Circumpolar Health
4–9 June 2000, Harstad, Norway. Symposia are planned on topics of particular importance to arctic indigenous peoples. Further information: http://www.hoarr.no/ ichc/ (e-mail: administrasjon@hoarr.no).

International Child Passenger Safety Conference
11–14 June 2000, Arlington, Texas. The conference will include both technical information regarding child restraints and programs that are being used to encourage their use. Further information: Center for Injury Prevention, Wisconsin (tel: +1 715 344 7583, e-mail: merritt@ciisafe.org).

Safety Promotion Research: Third International PhD Course
16–27 October 2000, Stockholm, Sweden. Further information: Moa Sundström, Karolinska Institutet, Department of Public Health Sciences, Division of Social Medicine, Norrbacka, 2nd Floor, SE-171 76 Stockholm, Sweden (fax: +46 8 33 46 93, e-mail: moa.sundstrom@socmed.sll.se).

First National Conference on Injury Prevention and Control
19–21 October 2000, Kananaskis, Alberta, Canada. This event will be preparation for Canada to welcome the injury world to Montreal in May 2002 for the 6th World Conference on Injury Prevention and Control. Two western Canadian centres are hosting the national conference—the British Columbia Injury Research and Prevention Unit and the Alberta Centre for Injury Control and Research. Themes will be road safety; occupational safety; intentional injuries; home, sport, and leisure safety; and post-injury control. Further information: www.med.ualberta.ca/acicr or www.bcriwch.ca/bcriwch.

Injury 2000 Prevention and Management
19–25 November 2000, Canberra, Australia. Further information: Injury 2000 Prevention and Management, PO Box 1280, Milton, Queensland 4064, Australia (tel: +61 (0) 7 3858 5410; fax: +61 (0) 7 3858 5510; e-mail: injury2000@iim.com.au).

10th International Conference on Safe Communities
21–23 May 2001, Anchorage, Alaska. This conference will focus on the opportunities in the new millennium for community based injury prevention programming. Further information: Diana Hudson, PO Box 210736, Anchorage, Alaska 99521, USA (tel: +1 907 929 3939, fax: +1 907 929 3940).

Nordic Safe Community Conference
21–24 August 2001, Denmark. Further information: Moa Sundström, Karolinska Institutet, Department of Public Health Sciences, Division of Social Medicine, Norrbacka, 2nd Floor, SE-171 76 Stockholm, Sweden (fax: +46 8 33 46 93, e-mail: moa.sundstrom@socmed.sll.se).

LETTERS TO THE EDITOR

Honorary editors honoured

Not one but two of our honorary editors have been honoured. We are proud and delighted that Sue Baker has received the American Public Health Association Award for Excellence and Hugh Jackson will be the recipient of the James Spence Medal from the Royal College of Paediatrics and Child Health. In both cases these awards signify not only that the recipients’ peers recognise their contributions to their respective disciplines, but also that the field of injury prevention is one worthy of such recognition, largely as a result of their efforts.

Open invitation from the International Poverty and Health Network to all health professionals

Editor,—Always and everywhere, the challenge for all health professionals is to understand, from a position of relative comfort, the nature and extent of the problems faced by the poor, the marginalised, and the vulnerable.1 Understanding, once even partial, achieved, creates empathy and a responsibility to advocate for redress. The International Poverty and Health Network (IPHN) was created in December 1997, following a series of conferences organised by the World Health Organisation (WHO). The aim of the network is to “integrate health into poverty eradication policies and strategies, promoting community partnership and intersectional action, as a means to achieve effective and sustainable results”. It was formed in response to the evidence of the persistent and growing burden of human suffering due to poverty and it invites others to join the endeavour.

Around 1.3 billion people live in absolute, grinding poverty on less than $1 per day despite the overall substantial growth of the world economy which doubled over the 25 years before 1998 to reach $24 trillion.2 Of the 4.4 billion people in developing countries, nearly 60% lack access to sanitation, and have no access to clean water, and about 20% lack access to health care of any kind; a similar proportion do not have sufficient dietary energy and protein.

Economic disparities both within and between countries have grown and in about 100 countries incomes are lower in real terms than they were a decade or more ago.3 By 1995 the richest 20% of the world’s population had 82 times the income of the poorest 20%. The world’s 225 richest people have the combined wealth equivalent to the annual income of the poorest 2.5 billion people in the world (47% of the world’s population).4 At the same time the world is facing an increasing scarcity of essential renewable resources from deforestation, soil erosion, water depletion, declining fish stocks, lost biodiversity, and challenges such as climate change which are likely to impact particularly on poor, vulnerable populations.

Despite the overall dramatic increases in life expectancy which have occurred over the last century, health professionals should be concerned about growing inequalities in health and wealth.5 The precipitous decline in life expectancy in Eastern Europe, particularly in Russia, is a graphic example of how health may deteriorate as societies face sudden social and economic change accompanied by growing poverty.6 The gap in life expectancy between selected Western European countries and Russia has widened from about three years for men in 1970 to around 15 years in 1995; the figures for women show a widening from four to 10 years over the same period.7 This health crisis is centred particularly on adult mortality from chronic diseases and external causes, principally violence.8 The East Asian recession has been deep and severe, resulting in substantial falls in average per capita income in five countries, most notably in Indonesia, with likely effects on poverty and ill health.

Many African countries have total external debts that are more than 100% of their gross national product. Although there has been progress in cancelling debt, only 22 of the 52 countries needing substantial or total debt reduction will actually see their annual payments reduced after the agreements made at the Cologne summit.9 Therefore much still remains to be done, including monitoring how the World Bank and International Monetary Fund (IMF) propose to implement the debt reduction programme and ensuring that the economic policy reforms they recommend are focused on reducing poverty.

Even among generally prosperous, industrialised nations, in countries including Spain, Finland, Sweden, Denmark and the USA, there are many examples of growing socioeconomic inequalities in health over the last 20 years or so.10 In the UK, there has been a widening of the differential in all cause mortality between social class V (unskilled) and social class I (professional) from a twofold...

It is a matter of particular concern that the lives of so many children are blighted by poverty and robbed of their physical and mental potential.1 Even in the USA more than one in four children under the age of 12 have difficulties in obtaining all the food they need. Ill health and poverty are mutually reinforcing and can generate a vicious cycle of deterioration and suffering. Ill health contributes directly to reduced productivity and, in some cases, to loss of employment. When it affects the principal earner in poor families it frequently has severe implications for economically dependent children, and other family members, who may no longer be able to nourish themselves adequately. By definition, poor people have very few reserves and may be forced to sell what assets they have, including land and livestock, or borrow at high interest rates, in order to deal with the immediate crisis precipitated by illness. Each option leaves them more vulnerable, less able to recover their former condition, and in greater danger of moving down the poverty spiral. In contrast, effective and accessible health care can protect the poor from spiralling into worsening economic problems with the onset of illness, and community based health care has the potential to make a major contribution to the building of social capital and to the strengthening of the community’s own coping mechanisms.

In the 20th century development was all too often equated with economic growth, but the link between economic prosperity and health is not automatic. A recent World Bank study of the causes of declines in mortality between 1960 and 1990 suggested that gains in income contributed around 20% to male and female adult mortality and under 5 mortality rate reductions.7 The researchers indicated that educational level among women and the generation and utilisation of new knowledge were more important factors. Poverty is a social construction with many dimensions including lack of basic education, inadequate housing, social exclusion, lack of employment, environmental degradation, and low income. Each of these diminishes opportunity, limits choices and undermines health.4 One key threat to health is the economic indicators focus primarily on income, whereas health indicators provide a broader perspective which will demonstrate the pre-eminent measure of the success or otherwise of development policies.8

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The IPHN is a worldwide network of people and organisations from the fields of health, business, non-governmental organisations, and government that seeks to influence policies to protect and improve the health of the world’s poor, with particular emphasis on the poorest in all countries. The IPHN urges that a balanced focus be maintained between social development and growth in per capita income; between the human and income dimensions of poverty; and between redistributive and market reforms. At the level of health, with particular focus on the needs of the poorest and most vulnerable, the aspiration is to achieve a balance between biomedicai and social approaches; between community based health development and an apportioning of resources between preventive, promotive and curative health care; and between physical and mental health.

Let’s emphasise fire sprinklers as an injury prevention technology!

EDITOR,—The recent article by Lynne Warda et al1 did a generally excellent job of reviewing the literature on prevention of fire injuries. Perhaps because the keywords did not include “sprinkler”, the authors neglected the tremendous value of automatic fire sprinkler systems in preventing deaths and injuries in house fires. The National Institute of Standards and Technology estimates that while smoke detectors alone can reduce the fire death rate by 52%, sprinklers alone could reduce deaths by 69% and the combination by 82%.2

Sprinklers protect people without requiring human action after a fire starts, and therefore go a major step beyond smoke detectors. Detectors can alert people to a fire, but fail to protect anyone who cannot easily escape without help.3 Sprinklers to the disabled, the intoxicated—the very people who are at greatest risk of dying once a fire is initiated. Detectors do nothing directly to prevent flashover and unacceptable heat, visibility, and toxic smoke conditions. In contrast, fire sprinklers are designed to effectively extinguish fires and to prevent these life threatening conditions.

Although the great majority of fire deaths occur in residential properties, no epidemiologic research on the impact of sprinklers on morbidity and mortality in private housing has been published. During the years 1985–91, the National Fire Incident Reporting System received reports of 7171 non-aron...
fires in homes with sprinklers and 126,240 non-arson fires in homes without sprinklers for the same fire departments. Preliminary results of research, which included validation of the outcomes and sprinkler status with the reporting fire departments, by Kay, one of the authors, indicate that the sprinklered homes had no fatal fires and 3.9 non-fatal injury fires per 1000 fires. In contrast, the non-sprinklered homes had 8.0 fatal fires and 36.7 non-fatal injury fires per 1000 fires.

In recent years, some jurisdictions in the United States have mandated sprinkler instal-

lation in new single family or multifamily

housing. Yet many builders and homeowners are disheartened by myths and misconcep-

tions, including a belief that sprinklers will “go off” by mistake and cause extensive water damage. In fact, sprinklers rarely activate accidentally and they sprinkle only rooms where there is fire. Not only do sprinklers improve life safety conditions by extinguishing a fire soon after onset, sprinkler dis-

charges of 30 gallons/minute cause much less property damage than fire hoses at 300 plus gallons/minute.

Many people also think that sprinklers are too costly, but advances in quick response sprinkler technology have improved performance and reduced costs through the use of plastic pipe. The installation cost ($1–1.50 per ft. of finished floor space) in a new house can be gradually recovered by reductions in insurance premiums.

Installation of automatic sprinkler systems in all new dwelling units and retrofitting in high hazard locations should be a high priority goal of the next decade.

ROBERT L KAY JR

Agency for Toxic Substances and Disease Registry

Johns Hopkins Center for Injury Research and Policy,

School of Hygiene and Public Health,

624 N Broadway, 5th Floor,

Baltimore, MD 21205-1996, USA


Argument for accident and emergency (A&E) collection flawed

EDITOR,—In a recent edition of Injury Prevention, Leonard and colleagues argue that the monitoring of recent changes in bicycle road safety policy in Scotland require “accurate monitoring of recent changes in bicycle road safety policy; like in England and Wales, no direct measures of injury severity are routinely collected.” A national computerised data collection system for all A&E departments in Scotland is likely to be expensive. A better use of any additional resources would be to introduce severity coding of injury admissions, and to use an indicator based on serious injury cases to monitor the effect of this and other policy changes.

JOHN LANGLEY

Injury Prevention Research Unit,

Department of Preventive and Social Medicine,

University of Otago Medical School,

PO Box 913, Dunedin, New Zealand

COLIN CRYER

Seinp Health and Health Cares Group,

Kings College London, Oak Lodge,

Davids Road, Rickmansworth, Hertfordshire, UK


Figure 1 Computed tomogram two days after the accident showing right frontal intracerebral haematoma with perifocal edema, small right subdural haemorrhage, and midline shift to the left.

We therefore recommend that party foam should be used only when there is adequate supervision of the dance floor. The edges of the floor should be rounded and made of impact absorbing material. Party foam must not be sprayed onto the faces of people dancing.

JOHANNES M MAYR

ERICH H SORANTIN

Department of Paediatric Surgery and Paediatric Radiology,

Austrian Committee for Injury Prevention in Childhood,

University of Graz, Auenbruggerplatz 34,

A-8036 Graz, Austria

e-mail: Johannes.mayer@juinigraz.ac.at
