Broken windows of the soul — when is child safety going to grow up?

The last quarter century has been a furious, fascinating chapter in the modern history of medicine. Twenty-five years ago the first South African human liver transplant was still 5 years in the future, part of the stomach was routinely removed for treatment of peptic ulcers, and HIV / AIDS was a strange new affliction troubling the gay community of San Francisco. Also in 1978, the Child Safety Centre was established in Cape Town to tackle the growing problem of childhood injury by means of strategies including educational programmes and media campaigns. Today, orthotopic liver grafts are limited only by the availability of donors, the notorious gastrectomy is little more than a historical curiosity, and HIV / AIDS tops every single international health agenda. In the course of the same 25 years the prevention of childhood injury has gone precisely nowhere. Why?

Various snappy tag-phrases have been used to describe 'trauma' as a generic South African issue; 'the neglected epidemic' and 'a malignant epidemic' being the most well worn. The former phrase is quaintly, if unintentionally, tongue-in-cheek, as there has certainly been no shortage of discussion or debate on the challenge of child safety. In October 1990, the reincarnation of the Child Safety Centre as the Child Accident Prevention Foundation of South Africa (CAPFSA) was commemorated by an *SAMJ* edition almost entirely devoted to the subject,[1] while injuries affecting all age groups have received notable coverage in more recent issues.[2,3] July 2002 also saw the launch of *African Safety Promotion*, a biannual publication and joint venture between the Medical Research Council and the University of South Africa (UNISA). In addition, the popular media have dramatically exploited individual cases of non-accidental injury, most notably that of baby Tshepang, mutilated by gang-rape at the age of 4 months. At the time of writing, the national road death tally for the 2002 / 03 summer holiday period has comfortably outstripped that of the comparable period 12 months previously. Quite predictably, a cacophony of outrage, blame and rhetoric scream from the daily media while the Ministry of Transport struggles to defend the failure of its costly Arrive Alive and Road to Safety programmes. Sadly, if we have nothing more than noise to fill the yawning gaps between words and action, and death and safety, the physical environment we live in remains a place of fear.

'Something must be done!' cried the late Duke of Windsor. Where injury prevention is concerned, the medical profession as a whole clearly agrees. However, like monarchs and political grandees, we too seem unsure, and certainly far from unanimous as to what exactly that mystical 'something' should be. However, unlike those outside our profession, our bemusement cannot be explained by ignorance. Indeed, a growing lobby of clinicians and public health experts alike demonstrate substantial insight into the magnitude of injury as a national health problem, as well as the matrix of intimately related injury determinants conceived by Haddon and Baker.[4] In this issue, Richard and Murray (p. 187) update their colleagues' earlier experience of ophthalmic injury, and discuss a range of demographic, socio-economic, behavioural and mechanical risk factors predisposing to eye injuries caused by toy guns. In particular, the authors highlight the need for more effective legislation governing the import, sale and ownership of toy guns, and the value of media campaigns in raising public awareness of the danger associated with toy guns in young, unsupervised hands. In doing so, the authors deserve to be commended for stepping well outside their formal clinical roles and promoting injury prevention, rather than simply adding another hospital-based study to the South African databank. But we need to ask ourselves how much real impact such a report will have on safety intervention if even the constitutional right to a safe environment, and a flurry of statutes designed to protect children, are yet to be given any meaningful effect. Perhaps it is not the trauma epidemic so much as failure to deal with it that should be described as 'malignant'. And, as the lead pellet inevitably seems to find the window of the soul, can doctors as a profession find a window in the seemingly impenetrable wall of inertia, and then raise a unified voice both clear and bold enough to shatter it?

Public health experts in particular have frequently cited lack of accurate regional occurrence and surveillance data as a major obstacle to the design and implementation of effective injury prevention programmes.[5] While this argument may justifiably stem from a combination of scientific principle and the plethora of hospital-based reports that demand a giant leap of faith (and economics) from presentation of selective data, to discussion of national preventive strategies, it is an argument which, I feel strongly, begs re-evaluation. The World Health Organisation's 1999 report on injury[6] provides the most detailed and accurately informed analysis to date of international fatal and non-fatal injuries in terms of their rank status and impact on the global burden of disease across six age groups. Certainly, each country or health region may reserve the right to interrogate and sub-analyse these data to some extent for their own purposes, but how academically indulgent can we afford to be while the carnage continues? The quest for a sound epidemiological basis for injury control is by its very nature an ongoing one, and surveillance could and should be conducted as a long-term strategy, but certainly not to the exclusion of injury control initiatives informed by data already available.

It has also been proposed that while establishing the prevalence of a health problem may help to provide goals for intervention, doing so will not necessarily identify those goals, or tell us how to achieve them.[7] To bridge that gap requires collaboration between a wide range of disciplines including epidemiologists, engineers, town planners, legislators, law enforcement agencies and others depending on the identifiable risk factors under scrutiny. In this and other ways much depends on the ability of the health professions to step outside their safety zones and reconcile rather than compromise scientific exactitude with the grim realities of the problem at hand, namely the ever-increasing threat of intentional and non-intentional injury to adults and children.

And what about those whose primary duty is is to save the lives and heal the wounds of the injured? Perhaps because the surgeon, the anaesthetist and the intensivist have as much of a vested interest in personal safety as the trauma victims-in-waiting, their voices should be at the forefront of the safety promotion lobby. The lobby requires an organised voice with meaningful representation from each and every professional body (SAMA, the Colleges of Medicine, Paediatric and Surgical Associations) in order to pressurise those who can and should commit themselves, at very least by burning preventable injury onto parliamentary and ministerial agendas. It is no longer enough to depend solely on medical journals and leader pages as a convenient channel for catharsis each time we become overwhelmed by trauma statistics. A unified, organised voice from the health profession as a broad-based and authoritative advocacy for child safety will prove indispensable as the key to elevating preventable injury from its dubious current status as a 'national disgrace' to its rightful place as a national health priority.

David Bass

Western Cape Department of Health
Cape Town

1. *S Afr Med J* 1990; **78:** 381-440.
2. Davies M. Child rape. *S Afr Med J* 2002; **92:** 664.
3. *S Afr Med J* 2002; **92** (October issue).
4. Haddon W, Baker SP. Injury control. In: Clark DW, Macmahon B, eds. *Preventive and Community Medicine*. Boston: Little Brown, 1981: 109-140.
5. Van Niekerk A, Duncan N. A new journal for the promotion of injury prevention in Africa. *African Safety Promotion* 2002; **1:** 1-4.
6. Krug E, ed. *Injury: ALeading Cause of the Global Burden of Disease*. Geneva: World Health Organisation, 1999.
7. Macintyre S. Evidence based policy making. *BMJ* 2003; **326:** 5-6.