GUEST EDITORIAL

Prevention of childhood injuries (part 2)

Trauma and violence are major causes of the burden of disease globally, and low- and middle-income countries bear the brunt of this scourge.[1] Unfortunately, in South Africa (SA), attempts to mitigate the devastating effects of trauma and violence on our young population are not a top priority of policy makers and health practitioners.

Two very important reference points guide our programmes that promote child safety in SA. The Convention on the Rights of the Child, as promoted by the United Nations, has been adopted in its entirety in SA.[2] These values are also entrenched in our constitution. It would, therefore, seem that our country is serious and committed to promoting the rights of children to survival and health, development, and protection from trauma and abuse. Reality paints a starkly different picture, however, with the obligation of the health and social development sectors to protect children's rights remaining feeble and without a commitment to a clear proactive course of action.[3]

Furthermore, child health comprises far more than the absence of disease. Striving for a healthy child population should include the goal of promoting child safety, and prioritising focused and appropriate assessment of childhood trauma, injury risk and resilience factors.[4]

This issue of CME makes a crucial contribution to child safety with regard to two major issues.

The first article[5] identifies energy poverty, prevalent in under-resourced communities, as a key contributor to the problem of child burns. The authors argue that prevention interventions are required, which should include access for impoverished families to clean, safe, and sustainable energy technologies. In the absence of grid electricity, a reality for many thousands of people in SA, the distribution of proven alternative domestic energy technologies, such as liquefied petroleum gas and solar power, is a long-term safety and energy priority.

The second article[6] assesses the use of child restraints in motor vehicles, as reflected by admissions to a dedicated paediatric trauma unit over more than a quarter of a century. The results of this study are rather disappointing – it seems we are not learning from our mistakes. It is high time that our medical and surgical fraternity takes cognisance of these disastrous preventable causes of childhood morbidity and mortality. The time to get involved and spring into preventive action is *now*.

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