educational messages that accompanied the introduction of legislation may also have had an effect – national radio and television advertising not only publicized the new legislation but also explained the dangers of using a mobile phone whilst driving.

Any trend in decreasing compliance could, therefore, be due to two reasons. First, following a period of compliance, some drivers may judge that the risk of being caught using their phone (and the penalty if caught) is small enough to warrant continued usage. And secondly, drivers may forget or downplay the dangers of using their mobile phone whilst driving, as a result of decreased publicity and education around the issue.

This calls for a policy response that addresses both enforcement and education. Indeed, the UK Road Safety Bill, currently before Parliament, seeks to increase the penalty for using a mobile phone while driving from £30 to £60 plus three penalty points.4 If introduced, these tougher measures should be combined with high-profile enforcement by police forces and regular education campaigns. This concurs with the conclusions of the New York study, which recommends vigorous enforcement campaigns accompanied by publicity in order to achieve long-term compliance.3

The Government should continue to monitor trends in usage of mobile phones whilst driving and alter policy accordingly. Depending on the impact of any changes made by the Road Safety Bill, the Government may have to consider even stronger deterrents to ensure that drivers respect this law aiming at protecting the public’s health.

References

Yours faithfully,

Paul Pilkington
Lecturer in Public Health
University of the West of England
Faculty of Health and Social Care
Glenside Campus
Bristol
paul.pilkington@uwe.ac.uk

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Concerning: Prevalence and awareness of risk factors and behaviours of coronary heart disease in an urban population of Karachi

Sirs,

Dodani et al.1 report the prevalence and awareness of risk factors for coronary heart disease in Karachi. In 2004, I conducted structured interviews with a convenience sample of 82 adults in three locations around Quito, Ecuador. Like Pakistan, Ecuador is a developing country with an increasing trend towards urbanization. Cardiovascular diseases (CVDs) are increasing in relative importance and now account for around 20 per cent of national mortality.2

I assessed participants’ socio-economic background and self-reported cardiovascular risk profile and asked each person, ‘What are the main causes of heart attacks?’. Most respondents were from the urban, lower middle class. Twenty-two per cent of participants gave a history of high blood pressure, 8 per cent smoked more than one cigarette a day and 6 per cent had diabetes mellitus. This is a prevalence of hypertension very close to that reported by Dodani et al. in Karachi, whereas the prevalence of diabetes and smoking is lower in Quito.

Yours faithfully,

Sandeep Johal
Medical Student
Jennifer Britt-Compton
Medical Student
Fiona Napier
Medical Student
Tim Marshall
Associate Professor
Public Health and Epidemiology
Department of Public Health and Epidemiology
University of Birmingham
Birmingham B15 2TT
t.marshall@bham.ac.uk

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Less than 65 per cent of participants in my sample could identify at least one cause of cardiovascular disease and less than 42 per cent identified more than one. Only 4 per cent of participants correctly named four or more correct causes. A diet high in fat was the most frequently mentioned significant risk factor, by 32 per cent. Smoking, hypertension and high cholesterol were identified by 20, 12 and 7 per cent, respectively. These findings are remarkably similar to the Karachi study.

The increasing global burden of cardiovascular diseases and populations’ widespread ignorance of them needs to be addressed.

References


Yours faithfully,

Richard Turner
Final Year Medical Student
University of Birmingham Medical School
Edgbaston B15 2TT
richturner77@yahoo.com

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