

PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	A cross sectional study of the health of southern African truck drivers
AUTHORS	Lalla-Edward, Samanta; Fischer, Alex ; Venter, WD Francois; Scheuermaier, Karine; Meel, Ruchika; Hankins, Catherine; Gomez, Gabriela; Klipstein-Grobusch, Kerstin; Draaijer, Melvin; Vos, Alinda

VERSION 1 – REVIEW

REVIEWER	Sergio Garbarino Department of Neuroscience, Rehabilitation, Ophthalmology, Genetics and Maternal/Child Sciences, University of Genoa Italy
REVIEW RETURNED	09-Jul-2019

GENERAL COMMENTS	<p>In this paper the authors have attempted a holistic approach to their own on the characteristics of a South African population of truck drivers. The lack of clear objectives and the inherent partiality of the adopted methodology has created only a series of results that are difficult to interpret and poorly connected to each other.</p> <p>Given the delicacy of the issue dealt with for public health and safety and its complexity, I do not consider the approach, analysis and discussion of data to be adequate, especially for a magazine like BMJ Open</p>
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REVIEWER	Rosie Cornish University of Bristol, UK
REVIEW RETURNED	16-Jul-2019

GENERAL COMMENTS	<p>This study presents results from a survey of truck drivers in South Africa, the majority of whom were from Zimbabwe. I feel that the manuscript would benefit from a more detailed background/context and rationale. Although it is clear that the objective of this study was to describe the health status of truck drivers in South Africa, and thus identify needs, it is not clear to me what the purpose of this was. To help understand this, I think it requires some background in terms of how healthcare is provided in the region. Was the aim to inform better provision of services for South African truck drivers or for truck drivers from South Africa and neighbouring countries? Do the truck drivers pay for such services or are they free? Can drivers from other countries access services in South Africa in the same way or would they access services in their own country? Also, I think it would be useful to present some additional comparative figures – the authors state that HIV prevalence was lower than the national average but do not give</p>
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	<p>other comparative figures. If, for example, the prevalence of overweight/obesity among truck drivers is similar to that in the whole population then this would suggest that there should be national initiatives targeting this risk factor instead of / in addition to just among truck drivers.</p> <p>Specific comments - major</p> <p>Strength and limitations of this study</p> <ol style="list-style-type: none"> 1. It is not clear what is meant by "this study explores how multiple risk factors and outcomes interact on a holistic scale". Specifically, this second strength appears to be simply be repeating the first strength - i.e. the fact that the survey was comprehensive rather than being restricted to a small set of (or individual) outcomes. <p>Results</p> <ol style="list-style-type: none"> 2. The authors should state what the participation rate was. How many invitation cards were given out and what percentage of these took part? 3. Were the authors surprised that 40% of the drivers reported never having drunk alcohol? This seems quite a high figure – it would be useful to either comment on whether this is what would be expected in this population or likely to be subject to mis-reporting. The same applies to physical activity – quite a high proportion were overweight or obese, yet over 40% reported doing strenuous physical activity at least twice a week. The potential for reporting error should be given as a limitation of the study. 4. In the mental health and sleep wellness section the authors report values of Cronbach's alpha for some of the measures. Did they carry out the reliability analysis? If so, this should be reported in the methods section; if not, then the values of Cronbach's alpha should be given in the methods section (with references), not in the results section (the results section should contain only results from the current study not from other studies). 5. Some of the tables contain very small cell counts. For example, 1 individual reported severe erectile dysfunction. It is good practice to suppress such small cell counts. In this case it would be simple to combine moderate and severe into a single category. This would not detract in any way from the overall message of the paper. <p>Minor comments</p> <ol style="list-style-type: none"> 1. No units of measurement are given for carotid intima-media thickness in Table 5. 2. Is carotid intima-media thickness really measured accurately to 3 decimal places? If not, the means should not be given to this degree of precision. The same comment applies to other measurements in Tables 4 and 5 (e.g. serum cholesterol is given to 2 decimal places, various cardiovascular measurements are given to 2 decimal places). The summary statistics should reflect how precise the individual measurements are. 3. In some tables, some of the percentages are given to 1 decimal place whereas others are given to the nearest whole number. This should be made consistent. 4. In the abstract, the singular term "truck driver" is used in two places where it should be plural (objectives and conclusion sections). 5. The last sentence in the second paragraph of the introduction appears to be incomplete.
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	<p>6. Use of the term "Baseline Data" in the methods section suggests that there was also follow-up data, whereas the study was cross-sectional. This should be changed to "Questionnaire data" or something similar.</p> <p>7. In Table 2 the percentage with multiple regular partners is given as 212 rather than 21.2.</p> <p>8. The authors discuss junk food, stating that 71% had at least one snack. I think this needs clarifying. A snack is not necessarily junk food. Did the questionnaire used specifically ask about unhealthy snacks? If so, then this should be stated. If not, then the term junk food should not be used for this item.</p>
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REVIEWER	Roger marshall A/Prof University of Auckland, New Zealand
REVIEW RETURNED	17-Jul-2019

GENERAL COMMENTS	<p>This paper addresses what I suppose is an important occupational health issue: the health of truck drivers in South Africa. It is a shapshot study of a sample of non-randomly selected truck drivers. I mean non-random in that truck stop sites were purposefully chosen , some chosen to boost participation of SA drivers.</p> <p>It is a "fact finding" study. Fairly comprehensive in its reach and topics addressed, but there is apparently no specific research question or hypothesis identified. This despite the claim in "Strengths and Weaknesses" that it explores how multiple risk factors and outcomes interact on a "holistic scale".. It does not do so. For example there is no consideration of whether there are race differences with respect to sex, accidents , chronic diseases etc. The paper would benefit from formulating a research question, or questions, and, as well as simple one-way tabulations, including cross-tabs and/or modelling.</p> <p>Small points:</p> <p>There were 614 responders, but no indication of numbers who declined. This should be specified.</p> <p>There is no explanation of where testing was done. After "invitation cards" were handed to drivers, what happened next?</p> <p>What is definition of "obese", i.e. the bmi cutoff.</p> <p>Table 4 should have a a normo-tensive category.</p> <p>Blood sugar counts do not add to 583.</p> <p>Claim that this is "largest of its design", probably exaggerated. What "design"?</p> <p>Table 1: suggest one decimal place for time measures.</p> <p>Table 1 Suggest the three mutually exclusive categories of Vehicle accidents presented.</p>
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VERSION 1 – AUTHOR RESPONSE

Reviewer 1

In this paper the authors have attempted a holistic approach to their own on the characteristics of a South African population of truck drivers. The lack of clear objectives and the inherent partiality of the adopted methodology has created only a series of results that are difficult to interpret and poorly connected to each other. Given the delicacy of the issue dealt with for public health and safety and its complexity, I do not consider the approach, analysis and discussion of data to be adequate, especially for a magazine like BMJ Open.

Thank you for the appraisal. We have addressed all comments and concerns presented by the editor and reviewers and improved the manuscript based on this feedback. We trust that by addressing all specified concerns, the manuscript meets the satisfaction of the journal, editor and reviewers.

Reviewer 2

This study presents results from a survey of truck drivers in South Africa, the majority of whom were from Zimbabwe. I feel that the manuscript would benefit from a more detailed background/context and rationale. Although it is clear that the objective of this study was to describe the health status of truck drivers in South Africa, and thus identify needs, it is not clear to me what the purpose of this was.

The final sentence of the Introduction has been updated to include a clear research objective and rationale:

“The Trucker Health Survey was developed to take a comprehensive snapshot of disease prevalence in truck drivers at selected South African locations.”

Has been changed to:

“The objective of this study is to use the Trucker Health Survey, which was developed to take a comprehensive snapshot of disease prevalence in truck drivers at selected South African locations, in order to determine what the common health problems are for truck drivers in South Africa. This body of formative evidence is aimed at guiding health programmers and researchers in developing prioritised truck driver healthcare interventions.

To help understand this, I think it requires some background in terms of how healthcare is provided in the region. Was the aim to inform better provision of services for South African truck drivers or for truck drivers from South Africa and neighbouring countries? Do the truck drivers pay for such services or are they free? Can drivers from other countries access services in South Africa in the same way or would they access services in their own country?

“In the Introduction, the background text was revised for improve clarity on context as follows: Driving long hours disrupts healthy sleep cycles and encourages drivers to lead a sedentary lifestyle. The risk of diabetes, hypertension, and heart disease is exacerbated by job-related stress, sleep disruption, nightshift-related circadian misalignment and limited access to healthy food at rest stops⁶⁻⁸. The travelling lifestyle may also provide limited access to healthcare facilities, especially for long-distance drivers from outside of South Africa, who easily and frequently cross borders. While traditional public health facilities are available to truck drivers across the country, truck drivers hardly access these services as they cannot take leave or clinics are not reachable by large trucks. In order to reduce barriers to access, mobile HIV clinics and roadside wellness clinics have been established to accommodate all drivers at no cost^{9,10}. The North-Star Alliance(NSA) clinics, for example, use trained clinical and outreach teams to provide primary healthcare services, HIV prevention and screening for other infectious diseases in converted shipping containers.

These initiatives have shown successes with the general uptake of healthcare, including HIV counselling and testing(HCT) for truckers^{10,11}, however, most of the focus is on preventing communicable diseases and very little is known about long-term health trends within this group. Current findings have come from studies and interventions that examine individual factors or conditions, but they do not incorporate a comprehensive health approach that includes NCDs^{12,13}. The objective of this study is to use the Trucker Health Survey, which was developed to take a comprehensive snapshot of disease prevalence in truck drivers at selected South African locations, in order to determine what the common health problems are for truck

drivers in South Africa. This body of evidence should establish a baseline to lead researchers towards future interventions.”

Also, I think it would be useful to present some additional comparative figures – the authors state that HIV prevalence was lower than the national average but do not give other comparative figures. If, for example, the prevalence of overweight/obesity among truck drivers is similar to that in the whole population then this would suggest that there should be national initiatives targeting this risk factor instead of / in addition to just among truck drivers.

The national prevalence has been added to the discussion:

“The frequency of hypertension and diabetes is globally in line with nationwide data from South Africa⁴⁰ but the frequency of overweight/obesity is double of what is seen in the general population (69% versus 31%)⁴¹. Reported HIV prevalence was less than the national average (13.1%)⁴², at 8%, and less than half were taking ART.”

The following references has also been added:

41. International Diabetes Federation. IDF Diabetes Atlas. Seventh Edition. Brussels, IDF. 2015, PMID: 31389103
42. National Department of Health (NDoH), Statistics South Africa (Stats SA), South African Medical Research Council (SAMRC), and ICF. 2019. South Africa Demographic and Health Survey 2016. Pretoria, South Africa, and Rockville, Maryland, USA: NDoH, Stats SA, SAMRC, and ICF.
43. Statistics South Africa. Mid-year population estimates 2018. Statistical release P0309.3. 2018.

Major Comments:

Strength and limitations of this study

1. It is not clear what is meant by "this study explores how multiple risk factors and outcomes interact on a holistic scale". Specifically, this second strength appears to be simply be repeating the first strength - i.e. the fact that the survey was comprehensive rather than being restricted to a small set of (or individual) outcomes.

We agree with the comment and have revised the strengths section accordingly. The strengths now read as follows:

- This study is possibly the largest and most comprehensive truck driver health and wellness survey completed in sub-Saharan Africa.
- Previous studies have been conducted in silos, while this study explores multiple risk factors along with common health conditions.

Results

2. The authors should state what the participation rate was. How many invitation cards were given out and what percentage of these took part?

The methods of recruitment did not facilitate the accurate tracking of invitation and participation. This has been added to the limitations:

- The comprehensiveness of the survey presented some limitations, due to convenience sampling (no tracked refusal rates), self-reporting, and the length of time required by participants.

This has been further clarified in the second paragraph of the methods section:

“As this was a harder group of people to recruit we employed various methods of invitation to participate. These included handing out invitation cards individually and to groups at truck stops, placing them on truck windscreens where no driver was available and recruiting at companies. In some instances the recruiter would be addressing one or two people and a group would form. These methods did not facilitate us accurately noting the number of invitations extended and as such no invitation log was maintained.”

3. Were the authors surprised that 40% of the drivers reported never having drunk alcohol? This seems quite a high figure – it would be useful to either comment on whether this is what would be expected in this population or likely to be subject to mis-reporting. The same applies to physical activity – quite a high proportion were overweight or obese, yet over 40% reported doing strenuous physical activity at least twice a week. The potential for reporting error should be given as a limitation of the study.

In South Africa, 38.3% of males abstain from alcohol (https://www.who.int/substance_abuse/publications/global_alcohol_report/profiles/zaf.pdf?ua=1), so these findings were not surprising, and thus not elaborated on. As for the physical activity and obesity these may seem inconsistent, but this may be explained by the fact that there are many confounders that affect obesity, not just physical activity. We have added the self-reporting as a limitation in the strengths and weakness section:

- The comprehensiveness of the survey presented some limitations, due to convenience sampling (no tracked refusal rates), self-reporting, and the length of time required by participants.

4. In the mental health and sleep wellness section the authors report values of Cronbach's alpha for some of the measures. Did they carry out the reliability analysis? If so, this should be reported in the methods section; if not, then the values of Cronbach's alpha should be given in the methods section (with references), not in the results section (the results section should contain only results from the current study not from other studies).

Thank you for this comment. We have added information on the Cronbach's alpha analysis and interpretation of the outcomes to the statistical analysis paragraph:

“Statistical analysis

In line with the aim of this paper data are descriptive only and reported as mean with standard deviation, median with interquartile range or count and percentages as appropriate. Internal consistency among items of the PHQ-9, PCL-5 and ESS questionnaires was verified with Cronbach's alpha tests. A score of > 0.7 -0.8 was considered acceptable, >0.8-0.9 good and any score >0.9 as excellent reliability.”

We also removed the following from results, and included them in the questionnaire data of the methods section:

“which was validated in a population of South Africans using English as a second language, similar to our Truckers' population²⁴. Overall, scores of 10 and less were considered as normal daytime sleepiness while 11 and more were considered as excessive daytime sleepiness. In addition, for our analysis, we further divided three categories of excessive daytime sleepiness, with scores of 11-12, 13-15 and greater than 16, corresponding to mild excessive, moderate excessive and severe excessive daytime sleepiness, respectively.”

After these changes, the results section for health and sleep wellness reads as follows:

“Depression was screened with PHQ-9 and the Cronbach's alpha value was 0.76. The questionnaire showed that 48(8.1%) participants had moderate depression, while none one of the respondents reported severe depression. The PCL-5 tool, however, identified PTSD in 21(3.6%) truck drivers, with a Cronbach's alpha of 0.92. Daytime sleepiness was assessed using the ESS and the Cronbach's alpha score was 0.77.” Overall, 77(12.7%) stated that they experienced moderate to severe excessive daytime sleepiness.”

5. Some of the tables contain very small cell counts. For example, 1 individual reported severe erectile dysfunction. It is good practice to suppress such small cell counts. In this case it would be simple to combine moderate and severe into a single category. This would not detract in any way from the overall message of the paper.

Under erectile dysfunction in Table 2, moderate and severe have been grouped as moderate-severe:

Erectile dysfunction (N=595)		
None	313	52.6
Mild	206	34.6
Mild-Moderate	65	10.9
Moderate	10	1.7
Severe	1	0.2

Has been changed to:

Erectile dysfunction (N=595)		
None	313	52.6
Mild	206	34.6
Mild-Moderate	65	10.9
Moderate-Severe	11	1.9

This has also been updated in the body of the text:
“only one (0.2%) person had severe ED.”
Has been changed to:
“only 11 (1.9%) people had moderate-severe ED.”

Minor Comments:

1. No units of measurement are given for carotid intima-media thickness in Table 5.
The unit ‘mm’ has been added to carotid intima-media thickness in Table 5.
2. Is carotid intima-media thickness really measured accurately to 3 decimal places? If not, the means should not be given to this degree of precision. The same comment applies to other measurements in Tables 4 and 5 (e.g. serum cholesterol is given to 2 decimal places, various cardiovascular measurements are given to 2 decimal places). The summary statistics should reflect how precise the individual measurements are.
Thank you for your comment. CIMT was measured to 3 decimals with dedicated software. We were guided by a body of literature that presented CIMT in 3 decimals. See for example the following publication:
Tzou WS, Douglas PS, Srinivasan SR, Bond MG, Tang R, Chen W, et al. Distribution and predictors of carotid artery intima-media thickness in young adults: the Bogalusa Heart Study. *Prev Cardiol* 2007;10:181-9.
3. In some tables, some of the percentages are given to 1 decimal place whereas others are given to the nearest whole number. This should be made consistent.
The percentages in all tables have been updated so that all values are given to one decimal place.
4. In the abstract, the singular term "truck driver" is used in two places where it should be plural (objectives and conclusion sections).
Truck driver has been pluralized in the abovementioned sections in the abstract.
5. The last sentence in the second paragraph of the introduction appears to be incomplete.
The last sentence in the second paragraph of the introduction has been revised:
“Despite these developments, very little is known about long-term health trends within this group, and current findings have come from studies that examine individual factors, but do not apply a comprehensive health.”
Has been changed to:
“The objective of this study is to use the Trucker Health Survey, which was developed to take a comprehensive snapshot of disease prevalence in truck drivers at selected South African locations, in order to determine what the common health problems are for truck drivers in South Africa. This body of evidence should establish a baseline to lead researchers towards future interventions.”
6. Use of the term "Baseline Data" in the methods section suggests that there was also follow-up data, whereas the study was cross-sectional. This should be changed to "Questionnaire data" or something similar.
The term baseline has been removed, and replaced by “Questionnaire” in the heading, and “health” in the first sentence.
7. In Table 2 the percentage with multiple regular partners is given as 212 rather than 21.2.
In Table 2, the multiple regular partners percentage has been corrected from 212 to 21.2.
8. The authors discuss junk food, stating that 71% had at least one snack. I think this needs clarifying. A snack is not necessarily junk food. Did the questionnaire used specifically ask about unhealthy snacks? If so, then this should be stated. If not, then the term junk food should not be used for this item.
We agree with this comment. The questionnaire did not capture the responses specifically as unhealthy snacks. Therefore the term ‘junk food’ has been replaced by ‘snacks’ in the results section.

Reviewer 3

This paper addresses what I suppose is an important occupational health issue: the health of truck drivers in South Africa. It is a snapshot study of a sample of non-randomly selected truck drivers. I mean non-random in that truck stop sites were purposefully chosen, some chosen to boost participation of SA drivers.

It is a "fact finding" study. Fairly comprehensive in its reach and topics addressed, but there is apparently no specific research question or hypothesis identified. This despite the claim in "Strengths and Weaknesses" that it explores how multiple risk factors and outcomes interact on a "holistic scale". It does not do so. For example, there is no consideration of whether there are race differences with respect to sex, accidents, chronic diseases etc. The paper would benefit from formulating a research question, or questions, and, as well as simple one-way tabulations, including cross-tabs and/or modelling.

The final sentence of the Introduction has also been updated to include a clear research objective:

"The objective of this study is to use the Trucker Health Survey, which was developed to take a comprehensive snapshot of disease prevalence in truck drivers at selected South African locations, in order to determine what the common health problems are for truck drivers in South Africa. This body of evidence should establish a baseline to lead researchers towards future interventions."

The term 'outcomes' has been removed from the strengths and limitations as it implied that tabulations or modelling was undertaken as part of this study. The lack of modelling or tabulations has also been added to the strengths and limitations:

- This study did not include any tabulations, modelling or regressions; it has established a comprehensive baseline of health problems and associated risk-factors for truck drivers in South Africa in order to lead research for future interventions.

Small Points:

1. There were 614 responders, but no indication of numbers who declined. This should be specified. The methods of recruitment did not facilitate the accurate tracking of invitation and participation. This has been added to the limitations:
 - The comprehensiveness of the survey presented some limitations, due to convenience sampling (no tracked refusal rates), self-reporting, and the length of time required by participants.

This has been further clarified in the second paragraph of the methods section:

"As this was a harder group of people to recruit we employed various methods of invitation to participate. These included handing out invitation cards individually and to groups at truck stops, placing them on truck windscreens where no driver was available and recruiting at companies. In some instances the recruiter would be addressing one or two people and a group would form. These methods did not facilitate us accurately noting the number of invitations extended and as such no invitation log was maintained."

2. There is no explanation of where testing was done. After "invitation cards" were handed to drivers, what happened next?

The following sentence has been added to Data Collection in the methods:

"The invitation card contained details for where and when drivers could go to the study clinic (participating NSA wellness clinic) for study enrollment. Dependent on when a truck driver decided to enrol he could go to the study clinic immediately upon invitation or any time within the study period."

3. What is definition of "obese", i.e. the bmi cutoff.

The BMI cutoffs were initially only presented in Table 4, but these have been added to body of the results as well:

"Calculated body mass index(BMI) revealed that 417 (69%) of all respondents were either overweight or obese."

Has been changed to:

“Calculated body mass index(BMI) revealed that 417 (69%) of all respondents were either overweight (BMI 25-29.9) or obese (BMI >30).”

The following reference has also been added:

39. Centers for Disease Control and Prevention. Defining Adult Obesity; Adult Body Mass Index (BMI). <https://www.cdc.gov/obesity/adult/defining.html> April 11, 2017. Accessed May 2, 2019.

4. Table 4 should have a normo-tensive category.

Table 4 on page 12 has been edited as follows:

Hypertension has been changed to Blood Pressure and includes a normotensive category. The included categories are based on the South African hypertension practice guide that defined hypertension as systolic >140mmHg or diastolic >90mmHg.

Hypertension - tested (N = 6 1 4)		
Grade 1(sys:140-159; dias:90-99)	151	2 4 . 6
Grade 2(sys:160-179; dias:100-109)	43	7 . 0
Grade 3(sys: >180-; dias:>110)	26	4 . 2
Total HTN(sys:>140; dias:>90)	220	3 5 . 8

Has been changed to:

Blood pressure - tested (N = 6 1 4)		
Normotensive (sys:<140; dias:<90)	394	6 4 . 2
Grade 1(sys:140-159; dias:90-99)	151	2 4 . 6
Grade 2(sys:160-179; dias:100-109)	43	7 . 0
Grade 3(sys: >180-; dias:>110)	26	4 . 2
Total HTN(sys:>140; dias:>90)	220	3 5 . 8

The following reference has also been added:

40. Hypertension guideline working group, Seedat YK, Rayner BL, Veriava Y. South African hypertension practice guideline 2014 [published correction appears in Cardiovasc J Afr. 2015 Mar-Apr;26(2):90]. Cardiovasc J Afr. 2014;25(6):288–294. doi:10.5830/CVJA-2014-062

5. Blood sugar counts do not add to 583.

The sample size for blood sugar has been changed from 583 to 604.

6. Claim that this is "largest of its design", probably exaggerated. What "design"?

The first sentence of the discussion has been revised:

“With over 600 participants, this study is possibly the largest of its design in sub-Saharan Africa, and the methods used have established a comprehensive baseline of health problems and associated risk-factors for truck drivers in South Africa”

Has been changed to:

“With over 600 participants, this study is possibly the largest and most comprehensive truck driver health and wellness investigation in sub-Saharan Africa, and the methods used have established a comprehensive baseline of health problems and associated risk-factors.”

7. Table 1: suggest one decimal place for time measures.

Thank you for your comment. Values have been presented in Table 1, and across all tables, to one decimal place where possible. In special instances we have presented the data to 3 decimal places based on reporting conventions for the measure.

8. Table 1 Suggest the three mutually exclusive categories of Vehicle accidents presented.

Thank you for this suggestion. We are not entirely sure whether you are asking us to have no overlap in the data between the involved and hospitalised categories or whether you are referring to three other categories. Therefore we have chosen to keep the categories as originally include but changed the order to improve the reading/flow.

Vehicle accidents (N=605)		
Never involved in accident	490	81
Involved in accident	115	19
Hospitalized from accident (n=115)	59	51

VERSION 2 – REVIEW

REVIEWER	Rosie Cornish University of Bristol, UK
REVIEW RETURNED	14-Sep-2019

GENERAL COMMENTS	The authors have addressed my previous comments.
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REVIEWER	Roger Marshall A/Prof University of Auckland, New Zealand
REVIEW RETURNED	10-Sep-2019

GENERAL COMMENTS	<p>This paper is limited in that it has no central hypothesis. It seems to be fine as a cross-sectional fact finding study. It presents statistics of some 50 or so individual variables. There are no cross-associations or correlations. I wondered how the researcher could put together a paper without curiosity to want to address basic some relationships? E.g. sleepiness-accidents, But I suppose later papers may address such issues.</p> <p>Probably it is up to the Journal editors to determine whether the topic and descriptive nature of the work is of sufficient interest. If so, I would say it is acceptable.</p>
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