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THE SAFE COMMUNITY NETWORK



VIOLENCE AND INJURY PREVENTION
WORLD HEALTH ORGANIZATION



WHO COLLABORATING CENTRE ON
COMMUNITY SAFETY PROMOTION AT
THE KAROLINSKA INSTITUTET

"JAMAIS PERSONNE NE PENSE QUE QUELQU'UN VA MOURIR AU
MOMENT LE PLUS INOCCASIONNEL MEME SI CELA SE PRODUIT
CONSTAMMENT, ET NOUS NE POUVONS PAS CROIRE QUE CELUI QUI
NE LE DEVRAIT PAS VA POUVTANT MOURIR PRÈS DE NOUS"

JAVIER MARIAS

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PREFACE

1. SAFETY AS A CONDITION FOR HEALTH - A NEW PUBLIC HEALTH APPROACH

1.1. A PILOT PROJECT FOR ACCIDENT PREVENTION: FALKÖPING, 1974

1.1.1. ONCE UPON A TIME...

More than twenty years ago, at a time when the word "airbag" was yet to be invented and motorcycle helmets were supposed to swing loosely around the grips of your motorbike, at this pre-historical age a group of scientists from Lund University came to Skaraborg County in Sweden in order to develop an injury prevention programme for a population of a quarter of a million inhabitants.

The municipality of Falköping had been chosen for the pilot project on the basis of a community diagnosis-oriented process, mainly according to the following criteria:

- a well-developed health service organization
- a well-differentiated commercial and industrial structure
- the availability of a similar control area (Lidköping)

It would serve as a testing site for both injury prevention research and later for interventions.

The project group set up certain **hypotheses**¹ for their work:

- 1) Accidents afflict the individual, the primary group and the community. The accident causes the individual mental, physical, social and financial suffering. The primary group - in most cases the family - suffers mental, social and financial strain through the accident. The accident entails heavy costs to the community, owing to increased absence from work and reduced capacity for work.
- 2) All accidents have one or more causes. If we can find the causes of accidents, we will also be able to find effective ways of preventing them.
- 3) Most people are aware of the accident hazards in their immediate surroundings but do not know whom to turn to for discussing them or how to eliminate the hazards and prevent accidents.
- 4) The individual citizen should be involved in accident prevention as much as possible so as to achieve long-term effects.
- 5) Accidents are usually described as events which have caused personal injury and/or damage to property and which are placed in different categories depending on the time and place of the accident, the part of the body injured

¹ Svanström, K./Svanström L.: A Safe Community-how to prevent accidents at the local level, 1989

etc. The necessary knowledge, experience and resources for a comprehensive accident prevention programme covering all kinds of accidents are lacking at present. Furthermore, preventive measures have reached different stages of development in different parts of the accident panorama.

- 6) An accident prevention programme must therefore reply to specific categories of accidents.
- 7) In a project of this kind, the most serious accidents, i.e. those leading to the severest injuries and deaths, and the most common types of accidents must be given priority.

The aim of the practical project of Falköping was not only to initiate activities together with the residents in order to reduce the accident rate; it should also increase the knowledge of the causes of accidents, the incidence of accidents in different sectors and the most effective preventive measures. Furthermore, it should enable the research group to draw a more precise picture of people's attitude towards accidents and accident-related problems.

1.1.2. THE FALKÖPING ACCIDENT PREVENTION PROGRAMME 1978- 1991

The project can be described in terms of three phases.

- (1) Surveillance** aimed at registering the importance of accidents and to describe general problems met in accident research .
- (2) Intervention** measures reached out to the areas and people that were exposed to major accident risks (*information - education - modification of the physical environment*)
- (3) Evaluation** of the intervention measures

It was only natural that the different phases were overlapping to a certain extent.

In 1978, Falköping initiated its injury registration programme, followed by an injury prevention programme in 1979.

After only a couple of years ' work, it was already possible to observe good results. From 113 per 1000 in 1978, the incidence fell to 98 per 1000 in 1981/82, 95 per 1000 in 1983 and 94 per 1000 in 1985. This corresponded to a reduction of home accidents by 27%, work accidents by 28% and road accidents by 28% up until 1981/82².

In the "control"- municipality of Lidköping, which was left untargeted by injury prevention, the injury rate did not decrease, it stayed on the same level.

THE IDEA OF A COMMUNITY-BASED APPROACH

One of the components that made the Falköping project successful was the fact that the leading role was played by the community itself.

Community-based programmes for safety promotion and injury prevention are able to answer to the particular needs of the citizens, to use existing local structures and potentials, to reach a high communication density with relatively low means and to develop quite quickly safety promoting standards within the social network.

² Svanström K./Svanström L. : A Safe Community - How to prevent accidents at the local level

Creative methods of education and environmental change joined with appropriate legislation and enforcement are an important beginning for the safety of a community. No single approach is sufficient for changing existing behaviour patterns, what is needed is a strong multi-sectoral approach.

Henceforth the idea of the community-based, bottom-to-top approach never got lost out of sight, it became one of the most basic principles for successful injury prevention and control projects.

1.2. FROM ACCIDENT PREVENTION TO SAFETY PROMOTION- WHO'S INVOLVEMENT

At about the same time the notion that injury prevention makes part and parcel of a world-wide public health strategy was also conceived by the world's largest public health institution, the World Health Organization. In the early Seventies it created a programme for Road Traffic Accidents Prevention at the European Regional Office in Copenhagen, which received regional and international responsibility. This programme should later move to WHO Headquarters in Geneva and become the Violence and Injury Prevention Programme.

A **technical network** was set up, comprising a number of national institutions working in a variety of disciplines and sectors but which were all mainly concerned with public health. The practical illustration of this network is to be found in the WHO Collaborating Centres, which constitute a world-wide technical reference body. This move by WHO to found a community of scientific interest in the area of safety, and to win technical co-operation for the creation, dissemination and application of knowledge is a basic component of the programme.

The second network is **operational**, involving health leaders and the administrators of districts and communities, who work in a decentralized system to promote safety within their geographical and political areas of responsibility. This work, on the basis of a common philosophy for action, should foster awareness, among politicians and appropriate group leaders in the community, of the value of decentralized and individualized management of safety matters.

WHO benefited from the experience in injury control acquired at the pilot projects in Sweden, the Swedish experts participated in the beginnings of the accident prevention programme in the European Region. From then on they were closely associated with the programme and helped to formulate its main aims. Together they decided not to limit themselves to pure accident prevention but to promote an overall safety concept for any environment.

The Swedish focusing on the community approach to the promotion of safety was in perfect agreement with the WHO philosophy of health promotion. Safety should indeed be seen as an essential component to health, and increasingly became viewed as an essential component of health activity at the community level.

Since safety promotion was an entirely new dimension of public health, it was crucial for the programme's success to develop science-based strategies, to have a clear vision about how safety affects health and to work out a concept how safety promotion could be put forward.

A major document has been published to present these conceptual and operational aspects of safety and safety promotion³. Although the paper has not been released before 1998, it

³ Safety and Safety Promotion: Conceptual and Operational Aspects; 1998

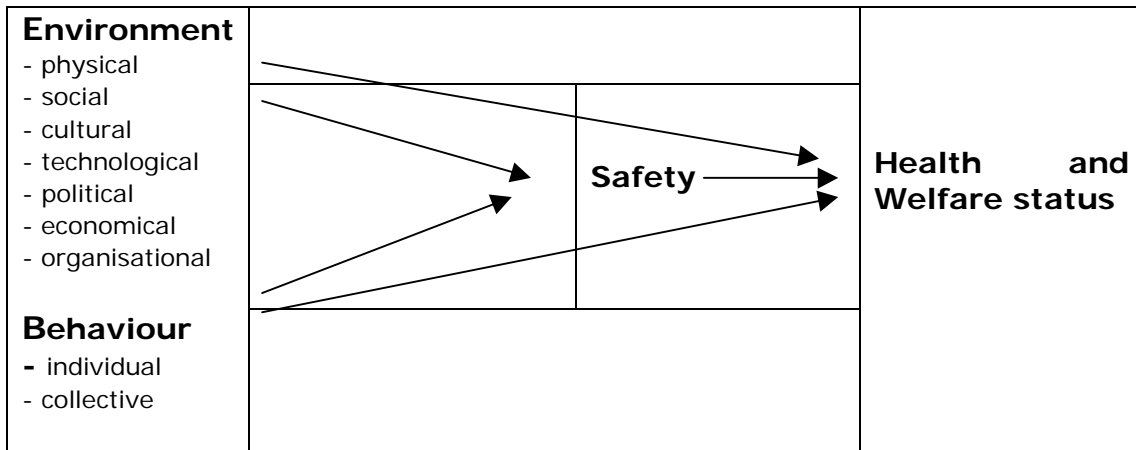
underlines what has been the programme's theoretical basement and spirit since its beginning in the late seventies. Some of its main paragraphs can be found in the next chapter.

1.3. CONCEPTUAL AND OPERATIONAL FRAMEWORK OF SAFETY PROMOTION

1.3.1. LINKS BETWEEN SAFETY AND HEALTH

Safety is a pre-requisite to the maintenance and improvement of the well-being and health of the population.

According to Maslow's needs Theory, safety is one of the fundamental needs of human beings, just like physiological needs⁴. Consequently, safety can be viewed as a prerequisite for maintaining and improving the health and welfare of a population (see Figure).



The health and welfare of a population is determined mainly by environmental conditions or exhibited behaviours. The effect of behavioural and environmental determinants on health and well-being is often a function on the level of safety attained.

1.3.2. SAFETY DEFINITION

"Safety is a state in which hazards and conditions leading to physical, psychological or material harm are controlled in order to preserve the health and well-being of individuals and the community. It is an essential resource for everyday life, needed by individuals and communities to realize their aspirations. "

Safety is considered as a state resulting from a dynamic equilibrium that is established between the different components of a given setting. It is the result of a complex process where humans interact with their environment. By environment, we mean not only the physical but also the social, cultural, technological, political, economical and organizational environments.

⁴ Maslow, 1968

On the other hand, safety must not be defined as a total absence of hazards. Indeed it should not necessarily be the ultimate goal to achieve, it could even be risky⁵. A certain level of danger can stimulate a state of vigilance which in turn can have a protective effect.

Furthermore, one can consider that, exposure to risks (dangers) is also necessary to the various apprenticeships of life. Exposure to minor hazards convey a certain “immunity” to resist against potentially more severe aggressions. Therefore, one should not seek to eliminate all dangers but rather seek to control dangers in order to protect the health and the well-being of individuals and the community.

Furthermore, this definition implies that safety is more than the absence of violent events or of injuries. Indeed safety must lead to a feeling of well-being essential to the blossoming of any individual or community.

Safety is a pre-requisite to the maintenance and improvement of the well-being and health of the population.

1.3.3. FOUR BASIC CONDITIONS FOR SAFETY

Attaining an optimum level of safety requires individuals, communities, governments and others to create and maintain the following conditions, whichever setting is considered:

- 1) a climate of social cohesion and peace as well as of equity protecting human rights and freedoms, at family, local, national or international level;**
- 2) the prevention and control of injuries and other consequences or harms caused by accidents;**
- 3) the respect of the values and the physical, material and psychological integrity of the individuals; and**
- 4) the provision of effective preventive, control and rehabilitation measures to ensure the presence of the three previous conditions.**

Safety concerns everybody. The whole community, including individuals, stakeholders, agencies and community groups must be mobilized to enhance the safety of the population. These basic conditions for safety must be present in all settings. A setting is considered a system having one or more finalities. Each setting is made up of many components (individuals, social, cultural, material, economical and technical elements) each of which fulfils a specific function. These components influence each other according to rules that are not always well known. A family, workplace, school, neighbourhood, town or a country can be regarded as a setting.





The climate of social cohesion and peace as well as of equity protecting human rights and freedoms, at a family, local, national or international level, refers to a fair society protecting the harmony between groups or communities of different races, sexes, ages, religions, countries, etc., without impeding the rights and freedoms of individuals. This condition must lead to a non-violent co-existence of these different groups or communities. It must also shelter the population from wars or any other form of organized violence. Finally, it must lead to lowering poverty and inequities both of which cause a great deal of safety problems at an international, national, local and family level.



The prevention and control of injuries and other consequences or harms caused by accidents means the presence of environments and behaviours that prevent the

occurrence of bodily lesions or other harm such as stress, social adaptation problems, post traumatic shocks resulting from a sudden transfer of energy (mechanical, thermal, electrical, chemical or radiant) or from sudden deprivation of any vital element (e.g. drowning, strangulation, freezing).

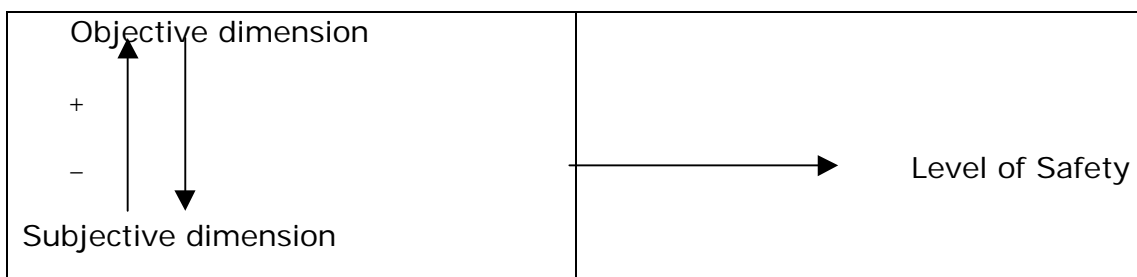
 **The respect of the values and physical, material and psychological integrity of the individuals** refers to the harmonious and non-violent co-existence of individuals within a life setting. This state allows each individual to live without the fear of being personally attacked, either psychologically (harassment, hateful remarks, etc.) or physically (assault, rape, etc.), and to be able to enjoy his or her belongings without fear of having them stolen or vandalized. Unlike the first condition (a climate of social cohesion and equity), which refers to interactions between groups, the present condition refers to interaction between individuals. It must be noted that suicide is considered a self-inflicted aggression resulting in part from a dysfunctional co-existence between an individual and his setting.

 **The provision of effective preventive, control and rehabilitation measures to ensure the presence of the three previous conditions** refers to resources (material, human and financial), to programmes and to services put forward in a community. These means are aimed at ensuring the presence of the three first conditions, minimizing the harms caused by an unfortunate event and facilitating the rehabilitation of individuals or communities affected.

1.3.4. SAFETY DIMENSIONS

There are two components to safety: one is objective and assessed by behavioural and environmental objective parameters and the other is subjective and appreciated according to the feeling of safety (or insecurity) of the population.

Both dimensions can influence each other either positively or negatively⁶. Indeed, improvement of the objective dimension can sometimes diminish the subjective dimension (e.g. the presence of numerous armed policemen in a given area to fight crime could generate a feeling of panic among some citizens). On the other hand, improving the feeling of safety can lead to a deterioration of the objective dimension (e.g. acquiring a firearm to feel better protected from attacks increases the risk of having a household injury). This dynamic between the objective and subjective dimensions of safety is sometimes even used to prevent some problems by inducing a feeling of insecurity in order to encourage safer behaviours that will benefit all (e.g. reducing the width of roads to slow traffic speed in school zones).



⁶ Forde, 1993

To improve the safety of the populations, it is necessary to consider these two dimensions for the following reasons:

- ☞ Much of what the population receives as a problem is well-founded even though it may not be demonstrable with objective parameters⁷;
- ☞ Safety promotion programmes need to be adapted to each community, its real-life as its subjective judgement about situations affecting it⁸;
- ☞ The dynamic between objective and subjective dimensions can better be taken into account while assessing the problems and planning the interventions;
- ☞ The objective and subjective dimensions of safety can differ dramatically because of the numerous stereotypes in our society. Since people have a tendency to behave according to a certain number of stereotypes, it is important to take them into account. For example, any type of marginal behaviour can represent a risk for some, because of the stereotype generated from the difference. In this case, it is important to distinguish the reality from the feeling of the population in order to protect the rights of certain marginal individuals⁹.

1.3.5. MAIN DIFFICULTIES TO OVERCOME IN ORDER TO IMPROVE SAFETY IN A COMMUNITY

While working through these processes, actors usually have to face some potential barriers. Firstly, two types of attitudes prevail in communities concerning some problems: fatalism and blaming the victim. Both attitudes, as we will see further on, are detrimental to the implementation of effective programmes for injury prevention and safety promotion. These attitudes hamper the implementation of efficient safety promotion programmes.

Fatalism is the attitude that fosters the belief that some events are preordained by destiny. It leads to the resigned acceptance of these events and to the belief that they are simply due to bad luck or to the unchangeable will of a Supreme Being. Fatalism results in **social acceptance** of some problems, which in turn hinders many efforts to prevent them. This social acceptance is sometimes even more important when a danger is related to an activity that an individual controls or is free to accomplish (e.g.: risk of getting hurt while driving a car). Such a danger is generally more acceptable than a danger resulting from an activity that one does not control (e.g.: operation of a polluting industry).

Blaming the victim, unlike fatalism, is the attitude that leads to the belief that a victim is responsible for his problems either because he made a mistake, because he did not adequately protect himself, because he has not been careful or because he deserves his misfortune. This attitude results partially from the fact that an individual can, to a certain extent, control his destiny, his environment or the risks related to some activities (e.g.: taking a walk alone at night, driving an automobile, mountain climbing). Such an attitude leads many to believe that education constitutes the one if not the only means by which some problems can be prevented, and this is to the detriment of other preventive interventions that focus on social, physical or economic

⁷ Hayes, Carter, et al., 1996

⁸ Forde, 1993; Svanström, 1993

⁹ Augoyard, 1990

environmental changes. For instance, battered spouses are often considered in their community as being responsible for their problems¹⁰. In fact, the main causes of this type of violence are related to social factors to act upon, such as social values, power struggles, and the nature of women and men relations in the society.

To a certain extent, these attitudes explain why the priority level given to safety issues does not accurately reflect the seriousness of the problem. Unfortunately, any spending on safety improvement is usually considered to be an expense rather than a wise investment. This attitude is a major impediment to many efforts toward the improvement of safety and forces the use of even more resources to convince people of the importance to act. This observation applies equally at the individual level (convincing an individual to use the best possible method of protecting himself), the organizational level (convincing a municipality to allocate resources to improve the safety of its citizens), and the community level (convincing the population of the merits of allocating collective resources towards improving safety).

The low priority granted to safety often means that existing and effective interventions never see the light of day. Even if actions are taken to fulfil a safety need, they are often only ineffective half solutions that are a waste of the minimal resources available. The low priority given to safety means that limited resources are invested in research activities. Therefore, it is very difficult to obtain the necessary funding for implementing or evaluating innovative projects.

¹⁰ Benedict, 1992

2. THE WHO SAFE COMMUNITY PROJECT

2.1. THE FIRST SAFE COMMUNITIES IN THAILAND AND SWEDEN

Several communities had started to get involved in WHO safety promotion programmes, communities that often enough had nothing more in common than the solemn wish to combat the growing number of injuries by using means and ways available in their particular environments. The idea came up to compare two completely different communities working with injury prevention and safety promotion and to observe their respective ways of dealing with the challenge. Would they adopt similar solutions or would their working methods differ as much as their cultural background?

The two communities chosen were Lidköping in Sweden, (which followed the Falköping example and had formed a reference group for accident prevention) and Wang Khoi in Thailand.

Although the evaluation of the communities' programmes took place only after the First World Conference on Accident and Injury Prevention (Chapter 2.2.1), we decided to present it beforehand.

The reason why we do so is the fact that the projects had actually started long before the World Conference (the responsible community officers from Thailand and Sweden indeed contributed to the conference), the evaluation indicated a peak but not the starting point in community the respective communities.

Furthermore, by first presenting the existing projects we illustrate part of the Safe Communities' bottom-to-top philosophy: **see what works on the local level with the scientific knowledge already available and benefit from these working projects by observing them and drawing best-practices conclusions for projects on a global level afterwards.**

2.1.1 WANG KHOI AND LIDKÖPING

Wang Khoi is a small village in the central part of Northern Thailand which had been founded in 1961, when the Government of Thailand offered free land in this area and the first families moved in. Although the move toward the development of a primary health care system in Thailand started in 1978, it was not until 1981 that Wang Khoi was included in the rural development plan and the poor infrastructure could be improved. In 1985, WHO negotiated for the Thai government to be involved in pilot projects for the Health for All initiative. Later that year under the guidance of the Ministry of Public Health, Mahidol University and WHO Thailand a steering committee was formed. The primary health care programme for Wang Khoi was developed as part of a wider programme in Nakonsawan Province. It supported education and

training for health officers and workers, the selection and recruitment of village health volunteers and communicators, activation of the village committee, education and information for the villagers, technical and moral support and supervision.

A more detailed prescription of the community's work can be found in chapter 5.2.



Lidköping is situated in Skaraborg County at the Lake Vänern. When the Trollhättan canal was opened in 1801, Lidköping was one of the municipalities benefitting most from this new trading possibility, especially from grain export. In 1860 it was the biggest town in the country and also the one in which business was liveliest. Today the city has about 36 000 inhabitants.

The main reason why Lidköping was the first municipality to adopt the tradition of the Falköping accident prevention programme and thereby utilised its experience was that Lidköping beforehand had served as a control area for the Falköping project. Results from Falköping were presented to the Lidköping health planners who were successively employed by the primary care committees during the early eighties.

Skaraborg County



2.1.2. THE FIRST TRAVELLING SEMINAR

Although the Wang Khoi Accident Prevention Programme, unlike Lidköping, had no connections to the Falköping programme, it proved to have similarities in facing with the task of using existing resources at the local level for injury prevention. This somewhat surprising fact was found out by the participants of the First WHO Travelling Seminar on Safe Communities. A report has been produced after participants had visited the two working projects and attended the First World Conference on Accident and Injury Prevention in Stockholm.

This report expressed a condensed view of the values and principles seen to lie behind safe community projects, possible methods and processes for creating new safe communities, specific recommendations about support needed at an international level and parallel developments in political and bureaucratic structures necessary to complement the Safe Community initiative¹¹.

The major recommendations formulated in the document consider (1) processes and methods, (2) support systems required, (3) the development of decision making structures to complement the community approach, (4) promotion and support of safe goods at national and international level and (5) the need for an international classification of accidents and injuries which is suitable for use in community based projects.

(1) ⇒ the outcomes of the questions that have been responded to by the participants about methods and proceedings to create a Safe Community are reflected in the "Twelve Designation Criteria".

(2) ⇒ it was recommended that WHO in conjunction with its collaborating centres develop a formal support structure for Safe Communities. Such a structure will guard against the use of inappropriate solutions and the waste of resources through reinvention of already tried solutions.

We are today talking about the "network" of Safe Communities, where the WHO Collaborating Centre for Community Safety Promotion at the Karolinska Institute is holding a coordination function. Additional expertise is actively identified and used from all WHO participant nations and, of course, the other WHO Collaborating Centres connected to the Violence and Injury Prevention Unit.

(3) ⇒ there is a need to encourage nations participating in the Safe Community initiative to examine national decision making systems and to develop new ways which are supportive to the efficient and effective implementation of national strategies to complement the work done in the community¹².

(4) ⇒ many of the problems which individual communities face in improving their own safety are generated by the nature of goods which are already available to them. The Safe Communities projects are likely to be most effective where complementary national programmes dealing with matters such as road safety and the control of dangerous products are in place.

(5) ⇒ While in the short term spot surveys and local classification of injury patterns would allow safe communities to develop and monitor their progress, it seemed senseless to require each community to develop their own way of classifying and aggregating data. Not only would there be duplication of effort but also difficulties in communication between Safe Communities due to different terminology.

¹¹ WHO Travelling Seminar: Formulating Guidelines for Safe Communities, 1989

¹² dito

This is why WHO together with some of its Collaborating Centres on Injury Prevention and Control has worked out an International Classification of accidents and injuries specifically for the purpose of designing and evaluating intervention projects including community interventions.

2.2. SAFETY - A BASIC HUMAN RIGHT

2.2.1. THE FIRST WORLD CONFERENCE ON INJURY PREVENTION AND CONTROL

In September 1989, 500 delegates from 50 countries followed the invitation of the Karolinska Institute and the Swedish National Board of Health and Welfare to attend the First World Conference on Injury Prevention and Control in Stockholm, sponsored by the World Health Organization. They met to discuss the immense injury and accident problem and the need for action and to prepare a manifesto concerning the aims and main themes as well as the outcomes and recommendations from the conference.

Among the participants were also those who, directly afterwards, should take part in the First Travelling Seminar (see above). They presented first findings from their respective working projects in Thailand and Sweden during the opening programme and thus contributed to the spirit of exchanging practical experience and technical expertise which animated the whole conference.

2.2.2. WHO HEALTH FOR ALL PROGRAMME

-an extract from the opening speech at the World Conference by the chief of WHO's Injury Prevention Programme -

"I would like first express my deep appreciation to the organizers of this conference.(...)

To our knowledge, it is the first time that a Conference on Accident and Injury Prevention with a world wide participation is being held. Furthermore it is likely to be the very first time that community safety promotion is being chosen as prime theme in such a Conference.

My role will consist in fact in introducing the three next speakers, who will illustrate the meaning of community safety promotion, in three different environments. They will present demonstration programmes which are carried out in co-operation with WHO as part of its programme on accident and injury prevention.

The WHO programme on accident and injury prevention proceeds from relevant Resolutions issued by the WHO Executive Board and World Health Assembly. It is one of the several programmes included in the 7th Global Programme of Work (GPW) of WHO which came to end in 1989 and in the 8th GPW which will cover the period 1990-1995 and which has been approved by the WHA. These technical programmes are the instruments to reach the WHO goals as they have been set by the Thirty-Fourth WHA in 1981 when it adopted the Global Strategy for Health for All by the year 2000.

Among the politics embodied in this strategy, at least three are of direct relevance to the discussion which will take place these days.

1) Reducing gross inequality in the health status of people.

2) Government responsibility for health of people with the connected need to establish mechanisms to co-ordinate development policies and programmes which have implication for

health and create explicit political commitment by all sectors concerned.

3) *Desirability to involve the community at large in matters related to individual and collective health, therefore establishing mechanisms to inform and motivate communities so that they assume greater responsibility for their health.*

I tend to say that the above policies apply "stricto sensu" to safety and, going a step further, that safety is part of the health and well-being of people. Governments have the duty to secure a safe environment to communities and back them up in their efforts to promote safety. Departments of Health need to appropriately contribute with other departments concerned in safety promotion and include safety promotion in health promotion activities at community level. Consequently the WHO programme aims at integrating safety or accident injury prevention in traditional health promotion protection programmes, with the constant preoccupation that health sector "know-how" complement efficiently actions from other sectors and thus play its "added-value" role.

2.2.3. THE MANIFESTO FOR SAFE COMMUNITIES

The Manifesto for Safe Communities, adopted in Stockholm, was one of the First World Conference's major outcomes.

"all human beings have an equal right to health and safety".

For the first time the fact that safety is a basic human right, equal to any other one stated in the UN Declaration of Human Rights and therefore worthwhile to promote and protect, had been outspoken by an international committee of experts; for the first time a document had been prepared which could serve to justify the need to implement projects in the field of injury prevention and safety prevention, and, even more, urged governments world-wide to do so.

The first part of the document gives a short overview about the conference itself and the subjects discussed, furthermore it offers a definition of the terms "accident" and "injury" and a world-wide situation analysis.

The second part, the actual manifesto, puts emphasis on **equity** ("Safety for all can be achieved by reducing injury hazards and by reducing the differences in accidents and injury rates among socio-economic groups¹³"), **community participation** ("People have the right, and some would say the duty, to participate in planning and implementing their community's safety programme.¹⁴") and **national and international participation** ("As part of its national health plan, each government should formulate a national policy and a plan of action to create and sustain safe communities¹⁵").

Furthermore, the Stockholm conference has identified four safe community action areas. The **recommendations for action** are:

¹³ Manifesto for Safe Communities; adopted in Stockholm, 20 September 1989 at the First World Conference on Accident and Injury Prevention

¹⁴ dito

¹⁵ Manifesto for Safe Communities; adopted in Stockholm, 20 September 1989 at the First World Conference on Accident and Injury Prevention

- formulate public policy for safety
- create supportive environments
- strengthen community action
- broaden public services

The Manifesto for Safe Communities closes with the **general conclusions**:

Participants at the First World Conference on Accident and Injury Prevention call for urgent and effective national and international action to develop and implement "Safe Communities" throughout the world. They urge governments, WHO, other international organizations, multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health and safety workers, and the whole world community to support national and international commitment to safe communities. Conference participants urge all parties to provide increased technical and financial support for this purpose. Developing countries, in particular, need such support. Participants help disseminate and implement the recommendations of this manifesto.¹⁶

2.2.4. THE UNITED NATIONS' 1994 REPORT ON HUMAN DEVELOPMENT

The following is stated in the 1994 report on human development:

"The world can never be at peace unless people have security in their daily lives. Future conflicts may often be within nations rather than between them, with their origins buried deep in growing socio-economic deprivation and disparities. The search for security in such a milieu lies in development, not in arms.

More generally, it will not be possible for the community of nations to achieve any of its major goals - not peace, not environmental protection, not human rights or democratization, not fertility reduction, not social integration - except in the context of sustainable development that leads to human security.

A new concept of human security

For too long, the concept of security has been shaped by the potential for conflict between states. For too long, nations have sought arms to protect their security.

For most people today, a feeling of insecurity arises more from worries about daily life than from the dread of a cataclysmic world event. Job security, income security, health security, environmental security, security from crime - these are the emerging concerns of human security

¹⁶ dito

all over the world. This should not surprise us. The founders of the United Nations had always given equal importance to people's security and to territorial security. As far back as June 1945, the US Secretary of State reported this to his government on the results of the San Francisco Conference:

The battle of peace has to be fought on two fronts. The first is the security front where victory spells freedom from fear. The second is the economic and social front where victory means freedom from want. Only victory on both fronts can assure the world of an enduring peace. No provision that can be written into the Charter will enable the Security Council to make the world secure if men and women have no security in their homes and in their jobs.

Several insights can help in redefining the basic concept of security:

- Human security is relevant to people everywhere, in rich nations and in poor. The threats to their security may differ - hunger and disease in poor nations and drugs and crime in rich nations - but these threats are real and common. Some threats are indeed common to all nations - job insecurity and environmental threats, in particular.
- When the security of people is attacked in any corner of the world, all nations are likely to get involved. Famines, ethnic conflicts, social disintegration, terrorism, pollution and drug trafficking are no longer isolated events, confined within national borders. Their consequences travel the globe.
- "It is less costly and more humane to meet these threats upstream rather than downstream, early rather than late. Short-term humanitarian assistance can never replace long-term development support."

The WHO Safe Community Network responds to the need of establishing a feeling of security in the field of violence and injury prevention. Additionally, by creating a feeling of responsibility and community among the people concerned by the issue, a number of "domino"-affects can be achieved. Wherever one starts acting positively, positive action will come back.

2.3. THE DEVELOPMENT OF THE SAFE COMMUNITY NETWORK

2.3.1. ESTABLISHING A WORLD-WIDE NETWORK

In order to respond to the final conclusions of the Manifesto ("Participants at the First World Conference on Accident and Injury Prevention call for urgent and effective national and international action to develop and implement "Safe Communities" throughout the world") and the recommendation number two of the First Travelling Seminar (\Rightarrow it was recommended that WHO in conjunction with its collaborating centres develop a formal support structure for Safe Communities), the WHO Collaborating Centre at the Karolinska Institute received primary responsibility for the development of the promotion of WHO's community safety programme.

Whereas in the beginning most of the communities involved in the programme could be found in Europe and here again in Scandinavia, the global embracement was pushed forwards by designating the first Australian and North American communities in 1994 and 1995. This

was also reflected in the fact, that the second and third World Conference on Injury Prevention were organised in Atlanta and Melbourne.

The Melbourne Declaration (1996) once more calls on global organisations and governments to establish national and regional networks for injury prevention policy and its implementation. The Safe Communities network is part of this world-wide partnership sharing responsibility for the safety of the citizens of the world.

2.3.2. THE NEED TO ADDRESS ALL TYPES OF INJURIES

Another aspect of the growing network was the need to address all types of injuries. In the beginning the movement had focused on unintentional injuries prevention, the need to address violence (intentional injuries) prevention became increasingly important when large urban areas communities started to be involved in the programme.

At the Dallas Conference in 1996 special emphasis was put on this new dimension, recognizing that although violence is not an uniquely urban issue, there are characteristically urban dimensions of violence that may be addressed through community participation models.

The Dallas Declaration stated that:

“any adoption of the Safe Community model for large urban areas must address violence and the fear of violence and encourage the existing Safe Communities to examine violence as a public health issue within their (typically) small communities, giving attention to domestic violence and self-inflicted violence.”

Safe Communities Network supports the development of the WHO Plan for Action regarding violence prevention and mitigation and is willing to take an active role in any plan that is endorsed by the WHO Executive Board.

2.3.3. REGIONAL NETWORKING

Global networking can only be achieved by partners who have a vision about their goals and objectives, who know about their similarities and who are willing to contribute to each others effort.

Nevertheless it is sometimes easier to work on a regional level, culture and language are much too often are reason why some act shyly in huge conferences while others tend to make their problems those of the rest of the world. Furthermore, by streamlining regional preferences and best-practice experiences it becomes easier for members of the different regions to articulate themselves on a global level.

This is why for several years (late nineties) regionalization has taken place.

At the moment three formal regional networks can be identified: the European

network, the Pacific Rim Network and the Nordic Countries Network (including communities in Europe and Northamerica). They all organise conferences and seminars and have thus contributed to safety promotion not only in their region but, considering the swall-over effect, in the entire world.

To enhance the positive effects of this decentralization, the Karolinska Institute is designating Affiliated Centres, responsible for technical and scientific support of communities within their region.

3. THE TWELVE DESIGNATION CRITERIA

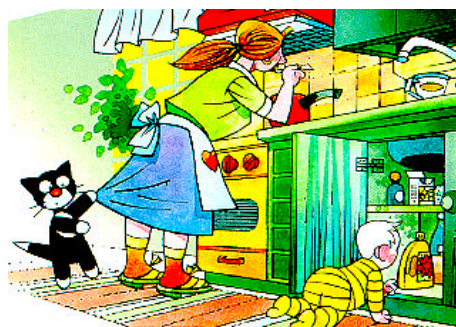
3.1. ORGANIZATION

- ☞ **There must be an inter-sectoral group working with safety promotion**
- ☞ **The community must be involved in solving the safety problems at all levels.**
- ☞ **The networks present in the community must take part in violence and injury prevention work.**
- ☞ **Collaboration must be established with local health-care institutions with regard to both surveillance and prevention.**

The formation of inter-sectoral groups requires that people from a wide variety of disciplines with a range of functions in the community are brought together for the common purpose of promoting action to identify and reduce hazards and unsafe situations. While many of these people belong to organizations which have a regional or national focus it is important to identify who has the local responsibility.

The creation of inter-sectoral groups at the local level first of all requires clearly defined community boundaries so that the relevant actors from the sectors can be identified. Furthermore each sector's key decision makers have to be identified, co-operation among these people established and incentives, involvement and persuasion to be used in order to obtain commitment to the project.

In some countries the relevant infrastructure may not be in place. It is the responsibility of governments and local authorities to ensure that the resources necessary are available to allow the sectors to function and to encourage intersectoral cooperation at all levels.



3.2. PROGRAMME

- ☞ **A safety programme encompassing all ages, environments and situations must be set up.**
- ☞ **The programme must emphasize high-risk groups and hazardous environments, and also promote fairness for exposed groups in the community.**
- ☞ **The programme must be long-term and not consist solely of short-term projects.**

It is important to recognize that the continued success of a project depends very much on the enthusiasm and commitment of the people, a feedback shaped to meet the needs of the community is therefore indispensable.

The linking of demonstration projects to permanent projects as well as linking to programmes in more than one sector may improve the chance of long-term support.

Safety Promotion should not end up to become fashionable for ten months, just because the king comes into town or because it looks so good in the newspapers.

Consistency has to be achieved, covering all ages, environments and situations and special emphasis has to be put on the high-risk groups, although they might be the most difficult ones to understand the importance of the issue.

3.3. DOCUMENTATION AND EVALUATION

- ☞ **Community officers must be able to document the frequency of injuries and causal patterns.**
- ☞ **Evaluation must take place, utilizing indicators demonstrating the effects of the programme and providing information on how change is being effected.**
- ☞ **Organizations within the community and their opportunities for taking part in safety promotion must be analyzed.**

All community safety promotion programmes must be accompanied by credible evaluation procedures which convince the participants, decision makers and the wider community that the programmes are essential and desirable. These evaluations are necessary to monitor the progress of the programme and to monitor milestones of development and achievement. However, evaluations must be kept to a minimum level necessary for the decisions to be made and not become an end in itself, absorbing scarce resources.

While fatality readily available and yardsticks, efforts understanding of

One of the programme is the



statistics are the most are often used as outcome must be made to get an morbidity patterns, too.

strengths of the comprehensive approach. In

safety promotion and injury prevention there is often pressure to do something. Anything. So things should be slowed down a bit to learn what the problems really are, looking for strategies to address them and finally evaluating the outcomes.

3.4 NETWORKING

- ☞ **The community should disseminate experiences both nationally and internationally.**
- ☞ **Be prepared to contribute to a strong network of “Safe Communities”.**

These are the last, and for most of the non-designated communities the most difficult criterion to accomplish.

Being part of the network, it is not enough to stay in one’s little corner of the world, the community is asked to contribute to safety promotion and to the network.

The ways to fulfil these tasks vary depending to the size and means of a community. Most of them have hosted a SafeComm-Conference or the training courses known as Travelling Seminars. These courses and conferences are dealing with new challenges concerning the programme and how to meet them; they serve as an exchange podium and attract new communities and groups who are interested in the movement (see Chapter 4.4).

A large number of communities have published their experiences or co-operated in scientific publications.

Some communities find themselves in a position where they are not able to organize any meetings or write papers and disseminate them. They can still receive visitors for an on-site demonstration or do like the Arjeplog community which decided to develop the Safe Community homepage. (www.ki.se/phs/wcc-csp)

4. CURRENT STATUS OF THE SAFE COMMUNITY NETWORK

4.1. DESIGNATED SAFE COMMUNITIES

European Region

www.primnet.se/public/injurynetwork/index.htm

Lidköping, Sweden	Elisabeth Svensson Milö-och hälsoskydd Lidköpings kommun 531 88 Lidköping	Tel: +46 510 770 264 Fax: +46 510 770 880 elisabeth.svensson@ltskar.se
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Motala, Sweden	Kent Lindquist Motala Safe Community Motala Municipality 591 86 Motala	Tel: +46 141-225 000 Fax: +46 141 577 14
Falköping, Sweden	Annette Holmberg Public Health Unit in Falköping Skaraborg County Council 521 85 Falköping	Tel: +46 515 872 30 Fax: +46 515 875 66
Corkerhill,Glasgow United Kingdom	Walter Morisson Corkerhill Community Council 31 Corkerhill Place Glasgow G 52	Tel: +44 41 882 4947
Safe Castlemilk, Glagow United Kingdom	Val McIntyre Community Safety Officer Castlemilk Partnership 141 Castlemilk Drive Glasgow G45 9UH	Tel: +44 41 634 1224 Fax: +44 41 634 2275
Harstad, Norway	Börje Ytterstad Harstad Sykehus St. Olavs gt.70 9400 Harstad	Tel: +47 77 01 51 27 Fax: +47 77 01 52 95
Falun, Sweden	Ann-Christin Jonell Milö and Hälsaskydd Falu komun 791 83 Falun	Tel: +46 23 83 641 Fax: +46 23 83 934 acj01@adm.falun.se
Krokom, Sweden	Lars Ranefall Krokoms komun 835 80 Krokom	Tel: +46 640 16165 Fax: +46 640 16105
Skövde, Sweden	Hakan Elwér Skövde kommun 541 83 Skövde	Tel: +46 500 468 209 Fax: +46 500 414 960 hakan.elwer@skovde.de
Arjeplog, Sweden	Bo Henricson Dr. Wallquists väg 930 90 Arjeplog	Tel: +46 961 14 800 Fax: +46 961 14 819 bo.henricson@nll.se
Vorarlberg, Austria	Franz Rein Initiative Sichere Gemeinden Realschulstrasse 6 68 50 Dornbirn	Tel: +43 55 7254 343 0 Fax: +43 55 7254 34345 sige@vol.at
Rotterdam, The Netherlands	A.JJ Voorham Municipal Health Service PO Box 70032 LP Rotterdam	Tel: +31 10 433 955 56 Fax: +31 10 433 943 4 voorhamt@ggd.rotterdam.nl

Tidaholm, Sweden	Ann Britt Johansson Public Health Unit in Tidaholm Skaraborg County Council PO Box 305 522 26 Tidaholm	Tel: +46 50 21 8059 Fax: +46 50 21 8141
Uddevalla, Sweden	Ingela Haglund Project Leader Uddevalla kommun 451 81 Uddevalla	Fax: +46 522 360 01
Boras, Sweden	Marie Persson Boras Municipality Komundelskontoret Centrum 501 80 Boras	Tel: +46 33 3580 47 Fax: +46 33 3580 47

American Region

Fort McMurray (Wood Buffalo), Canada	Ed Kamps Wood Buffalo Safe Healthy Community PO Box 5361 Fort McMurray, Alberta T9 H9G4	Tel: +403 743 0006 Fax: +403 743 0006
Dallas, United States of America	Linda Harris, Interim Director Greater Dallas Injury Prevention Center (GDIPC) 6300 Harry Hines Boulevard, Bank One Building Suite 300 Dallas, 75233 Texas	Tel: +1 214 590 4455 Fax: +1 214 590 4469 lvhar@parknet.pmh.org
Anchorage, United States of America	George A. Conway MD, MPH, Chief CDC, National Institute of Occupational Safety and Health Division Safety Research Alaska Field Station 4230 University Drive Grace Hall, Suite #310 Anchorage, Alaska 99508	Tel: + 1 907 929 3941 Fax: + 1 907 929 3940 goc1@cdc.gov

African Region

Eldorado Park, Johannesburg South Africa	Mohamed Sedat, Director Centre for Peace Action PO Box 293 1812 Eldorado Park, Johannesburg	Tel: +27 11 34 23840 Fax: +27 11 94 53956 psych@icon.co.za
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Pacific Region

Illawarra, Australia	Wendy Cook-Burrows Illawarra Safe Community 49 Kembla Street Wollongong, NSW 2500	Tel: +61 42 26 5000 Fax: +61 42 26 5339
Hume City, Australia	Lynne Galanti/ Moya White Safe Living Programme Hume City Council PO Box 119 Broadmeadows, VIC 3047	Tel: +61 3 92 05 2528 Fax: +61 3 30 90 109
Noarlunga, Australia	Richard Hicks Healthy Cities Noarlunga Noarlunga Health Services Alexander Kelly Drive Noarlunga Centre, SA 5168	Tel: +61 883 849 362 Fax: +61 832 6 3696 richardh@nhs.health.sa.gov.au
La Trobe, Australia	Henk Harberts La Trobe Shire Council PO Box 345 Traralgon, VIC 3844	Tel: +61 351 731 506 Fax: +61 351 731 558 henkha@latrobe.vic.gov.au
Parkes, Australia	Vicki Poxon Parkes Injury Prevention Project PO Box 232 Parkes, NSW 2870	Tel: +61 2 68 62 1866 Fax: +61 2 68 62 1082
SHOROC, Australia	Susan Gomola SHOROC Warringah Council Pittwater Road: DeeWhy 2099	Tel: + 61 2 9982 31 78 Fax: + 61 2 9942 24 60 susan.gomola@warringah.nsw.gov.au
Ryde, Australia	Mary Psaromatis Ryde Health Promotion Unit 37, Fourt Avenue, Eastwood Sydney, 2122	Tel: + 61 2 98 58 0750 Fax: + 61 2 98 58 0733 mpsaroma@doh.health.nsw.gov.au www.slsw.gov.au/ryde
Waitakere, New Zealand	Margaret Devlin Waitakere City Council Private Bay 93 109 Henderson, Waitakere City	Tel: + 64 9 836 8000 ext 8540 Fax: + 64 9 836 8073 margaret.devlin@waitakere.govt.nz
Waimakariri, New Zealand	Safe Waimakariri Community Team Waimakariri District Council Private Bag 1005, Rangiora, North Canterbury	Tel: + 64 3 313 6136 Fax: + 64 3 313 4432 r.steel@wmk.govt.nz

Asian Region

Whang Khoi, Thailand	Sriwangse Havanonda 73/015 Ake-Burapa 8 Muang Ake Project 1 Luk-Hok, Amphur Muang 12 000 Pathum-Thani	Tel: +66-2 997 2100 1 Fax: +66 2 281 5035
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4.2. AFFILIATE SAFE COMMUNITY SUPPORT CENTRES

As the most fruitful kind of partnerships are often those that prosper under the same local circumstances and benefit from short-distance relations, academic institutions around the world are encouraged to become part of the Safe Community network in order to ensure support in terms of data, research and advice for the Safe Communities in their country or region.

The designation criteria which have to be fulfilled by an institution that wants to be designated as an "Affiliate Safe Community Centre" are similar to those required by the communities themselves.

1. Demonstrate the existence of mobilisation strategies to develop cross-sectoral groups responsible for injury prevention
2. **Support, nurture and demonstrate** the involvement of the local community networks
3. **Facilitate community-based strategic planning processes** that support a programme covering all ages, environments and situations
4. Create interest and action that result in programmes that show concern for high risk groups and environments and aim particularly at ensuring justice for vulnerable groups
5. **Provide data and support** to those responsible to document the frequency and causes of injuries
6. The programme/injury prevention service must be long-term rather than short-term
7. **Provide and support those responsible to utilise appropriate indicators to evaluate processes and the effects of change**
8. **Assist and guide communities to analyse** their community's organizations and their possibility of participation in injury prevention programmes
9. Support the involvement of health care organizations within communities to be involved in both the registration of injuries and the prevention programmes
10. Facilitate the involvement of all levels of the community in solving the injury problem
11. Disseminate experiences both nationally and internationally

12. Be prepared to contribute to a strong network of "Safe Communities"¹⁷

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Royal Children's Hospital Melbourne, Australia	Jane Shield Child Safety Centre Royal Children's Hospital Melbourne Flemington Road Parkville Victoria, 30 52	Tel: + 613 9345 5085 Fax: +613 9345 50 86 shieldja@cryptic.rch.unimelb.edu.au www.rch.unimelb.edu.au
Safe Communities Foundation Edmonton, Canada	Safe Communities Foundation 64 Charles Street East, Suite #201 Toronto, M4Y 1T1 Ontario	Tel: + 416 964 0008 Fax: + 416 964 0089 info@safecommunities.ca www.safecommunities.ca
Injury Prevention Centre of Alberta, Canada	Joanne Vincenten Injury Prevention Centre of Alberta EDC 4075, 8308 - 114 Street T6G 2V2 Edmonton	Tel: + 403 492 6019 Fax: + 403 492 7154 joanne.vincenten@ualberta.ca www.med.ualberta.ca/acicr

4.3. THE ROLE OF THE WHO COLLABORATING CENTRE ON COMMUNITY SAFETY PROMOTION - KAROLINSKA INSTITUTET

The Department of Social Medicine at the Karolinska Institute was officially appointed as a WHO Collaborating Centre at the First World Conference on Accident and Injury Prevention after having actively contributed to the development of the WHO programme both technically and as a fund raiser.

This collaboration is part of a larger programme of co-operation between the World Health Organization, Violence and Injury Prevention Programme and the world scientific community, aimed at supporting the development, adaptation and the use of methods for violence and injury prevention. This scientific collaboration has two objectives:

¹⁷ Submission by Monash University Accident Research Centre for recognition as an Affiliate of the World Health Organisation's International Safe Communities Network

- To promote appropriate multisectoral approaches and service infrastructure through stimulation of effective national policy and programme development to control injury (intentional and non-intentional) in the community;
- To develop accident and injury safety technologies or socio-behavioural alternatives and support their continuity with the aim of preventing accident risk occurrence or minimizing resulting injury or disability.

4.3.1. COMMITMENTS OF THE DEPARTMENT OF SOCIAL MEDICINE AT KAROLINSKA INSTITUTET

- **Planning and policy support** : the Department of Social Medicine at the Karolinska Institute (Dep Soc Med, KI) along with other collaborating centres, will assist the WHO Global Programme for Accident Prevention by participation in the Programme Advisory Group or other planning and policy groups, providing advice on programme plans and directions and supporting efforts to enhance the global attention to injury control.
- **Methodology support**: The Dep Soc Med, KI, will serve as a part of a health research methodology support group, providing on protocols for research on injury prevention. Such support will focus on injury epidemiology (descriptive, analytic and preventive action oriented). Focus on involvement of the local community in epidemiological registration and development of preventive programmes - community intervention based on community diagnosis. Evaluation of such programmes have been developed and thus offers a base for guidance through the WHO global programme on violence and injury prevention.
- **Research strengthening and training**: the Dep Soc Med, KI, will also be part of an active network of centres collaborating in a WHO supported international programme on injury prevention research strengthening and training. The first priority of this programme is to strengthen the capacity of national institutions to conduct epidemiological studies in national injury priorities. The second, closely related priority of the programme is to train individual researchers. The Dep Soc Med, KI, will assist this programme through participation in overall planning and in the development of specific training for research trainees which benefit KI, the Swedish National Board and Welfare, WHO and trainees. This role will be facilitated by the fact that the Dep Soc Med, KI, is the responsible scientific institution involved in the implementation of a nationwide HFA-accident prevention programme in Sweden within the health sector and in close cooperation with other sectors and NGOs. Additionally, the Dep Soc Med, KI, co-ordinates training courses for Safe Communities, mostly in the form of [Travelling Seminars](#).
- **Scientific meetings and Consultantships**: the Dep Soc Med, KI, when invited, will participate in scientific meetings. It is envisaged that the Dep Soc Med, KI, will provide expertise in the field of Community Intervention Methods (based on intersectoral cooperation and voluntary participation) as well as evaluation. In order to offer a scientific exchange forum for Safe Communities and other experts, it organizes together with the communities annual "[International Safe Community Conferences](#)"
- **Information/Data Analysis and Reports**: the Dep Soc Med, KI, will provide reports on injury epidemiology and control in Sweden but to some extent also from other Nordic countries. Sweden has a well developed reporting system in almost all areas of interest for accident prevention. Validation studies have been made on such registers: like outpatient, hospital discharge, death certificate, police, occupational injuries, insurance company registers and others. The experiences from these will be available and of value in preparation

of reports as well as development of global information-systems in collaboration with WHO.

- **Organization of Injury Prevention Programmes at Community Level:** the Dep Soc Med, KI, will provide reports on the design, implementation and evaluation of injury prevention programmes as they are tested in Sweden. When appropriate to both parties in the collaboration, consultancy will be offered on the development of injury control programmes at the community level. The Collaborating Centre is responsible for [reviewing applications from communities](#) striving to become designated following the Twelve Designation Criteria.
- **Production of Technical Documents and Publication:** along with other collaborating centres, Dep Soc Med, KI, will provide technical input in the preparation of technical documents and publications. Besides these technical documents, the Dep Soc Med, KI, also publishes a [newsletter "Safe Community News"](#) for keeping all the members in the network informed about the latest achievements, conferences to come up etc.

4.4. CONFERENCES AND TRAVELLING SEMINARS

4.4.1. INTERNATIONAL SAFE COMMUNITY CONFERENCES

The Collaborating Centre at Karolinska Institutet was responsible for organizing:

- the First International Conference on Safe Communities held in Falköping, Sweden on 3-5th June, 1991
- The Second International Safe Communities Conference held in Glasgow, Great Britain, 7-9th September, 1992
- The Third International Safe Communities Conference held in Harstad, Norway, 6-8th June, 1994
- The Fourth International Conference on Safe Communities held in Fort McMurray, Canada, 5-8th June 1995
- The Fifth International Safe Communities Conference held in Hume and LaTrobe, Australia, 22-26th February, 1996
- The Sixth International Conference on Safe Communities held in Johannesburg, South Africa, 15-18th October, 1997
- The Seventh International Conference on Safe Communities held in Rotterdam, The Netherlands, 13-15th May, 1998
- 11-13th April, New Zealand
The First Pacific Rim Region Safe Community Conference, Waitakere, New Zealand
"Creating Safe Communities...What Works?"
- 26-28th August, Iceland
The Third Nordic Safe Community Conference, Reyjavik, Iceland
"How can we improve equity in safety?"
- 4-5th October, Austria
-The Eighth International Safe Community Conference, Vienna, Austria

"Networking for Safe Communities"
-The First European Region Safe Community Conference

- 18-20th October, Sweden
10 years with experience on Safe Community activities. A presentation of the results.
Lidköping, Sweden
The 0-vision in Traffic Safety

4.4.2. TRAVELLING SEMINAR

The First Travelling Seminar between Whang Khoi and Lidköping did not rest the only one, a long tradition Travelling Seminars has developed since then. A lot of them are conceived as "satellite events" to World Conferences on Injury Prevention and Control or can be found in the context of the International Safe Communities Conferences.

The Travelling Seminars organized so far are:

- The 1st Travelling Seminar, held in Sweden and Thailand in September/October 1989 in collaboration with the Ministry of Health in Bangkok, Thailand.
- The 2nd Travelling Seminar, organized in Sweden in late May 1991 in collaboration with the Ministry of Health of Thailand and the WHO Collaborating Centre (Research and Training in Safety Technology) in New Delhi, India.
- The 3rd Travelling Seminar, held in Navajo Nation, USA, in May 1993.
- The 4th Travelling Seminar "How to Create Supportive Environments for safety with Special Emphasis on Socially Exposed Groups", held in Sweden-Norway, May-June 1994.
- The 5th Travelling Seminar "Creating Safe Community Programmes with Special Emphasis on Vulnerable Groups", held in Navajo Nation, USA and in Fort McMurray, Canada, May/June, 1995.
- The 6th Travelling Seminar "How can the Swedish Safe Community Programme be adopted in Countries of Central/Eastern Europe and Southwest Asia?", held in Stockholm, Falun and Skövde, Sweden, October/November 1995.
- The 8th Travelling Seminar, held in Australia, February 1996.
- The 9th Travelling Seminar "Consolidating Communities against Violence", held in South Africa, October 1997.

4.4.3. UPCOMING EVENTS¹⁸

1999

14-20th November, Egypt
Safe Community Seminar
Alexandria, Egypt

2000

15-27th February, Bangladesh

¹⁸ as on www.ki.se/phs/wcc-csp/conferences.html

Travelling Seminar

23-25th February, Bangladesh

The Ninth International Conference on Safe Communities, Dhaka, Bangladesh

"Setting Child Safety Priority within Safe Community Framework"

2-8th March, India

International Course Safety Promotion Seminar, Delhi, India

5-8th March, India

The 5th World Conference on Injury Prevention and Control, Delhi, India

4-10th June, Harstad, Norway

"The Millennium Congress- Eleventh Congress on Circumpolar Health"

with circumpolar Injury Prevention as cooperation between the Nordic Society of Circumpolar Health and University of Tromsø

5. MAJOR SAFE COMMUNITY STRATEGIES AND EXAMPLES

5.1. FALKÖPING, SWEDEN

The Falköping Accident Prevention Programme (FAPP) is based in Skaraborg County, Sweden. An injury register was started in 1978 and intervention began in 1979. Three years later the injury rate had fallen by 23%.



By the end of 1982, in accordance with the original programme design, the Reference Group for Safety Promotion was dissolved. Responsibility for the accident prevention programme was absorbed into existing local structures and the lessons learned were disseminated to the County's 15 other municipalities.

An overview of the activities performed during the following years is given in the table¹⁹ below.

1978:	Registration starts with the Fapp surveillance system
1979:	The FAPP cross-sectoral intervention group established; preventive work in traffic, work and children/home starts
1980:	Prevention regarding falls starts
1982:	County-wide programme in child health care starts
1982:	FAPP cross-sectoral intervention group breaks up
1983:	Falköping Local Health Committee adopts the FAPP
1986:	Transport Deficiency Analysis System introduced in Falköping
1987:	Bicycle helmet programme introduced in Falköping
1990:	Planning of the First International Conference on Safe Communities starts
1991:	The First International Conference on Safe Communities; FAPP cross-sectoral intervention group re-established
1992:	Registration of injuries according to the national surveillance system starts

However, with the disbanding of the Reference Group, the strength of the former intersectoral collaboration declined. Even when new activities were introduced, they were less intensive than before and tended to be implemented by one particular municipal department or sector²⁰.

Then, in June 1991, the municipality of Falköping and the County Council of Skaraborg were host to the First International Conference on Safe Communities.

To satisfy the criteria for a Safe Community, the FAPP was reorganized and a number of safety promotion activities revitalized. A political management group with representatives from both the Health Care Sector and the Municipality Board was established. Four intersectoral working groups dealing with data collection, child safety, traffic safety and safety for the elderly were formed and linked to the management group.

These organizational changes and the improved surveillance system introduced in 1992 reconciled FAPP as consistent with the WHO criteria.

The Falköping experience proved the rightness of the designation criteria, there "must be a cross-sectoral group responsible for the programme" (criterion #1) it is indeed indispensable for an effective working programme.

¹⁹ Svanström, L./Schelp L./Ekman R./ Lindström A.: Falköping, Sweden, ten years after: still a safe community? May 1995

²⁰ dito

5.1.1. ORGANIZATION

As mentioned above, a second, newly formed intersectoral reference group became responsible for the "Falköping -A Safe Community" project in autumn 1991.

Within this reference group four separate work groups were created, each one focusing on a particular field of injury prevention and control:

- children and youth;
- the elderly;
- traffic accident prevention;
- data collection

The reference group includes representatives from the local authority, the health care and medical services, police authorities, voluntary organizations and individuals.

A political management group is responsible for the whole programme.

During 1991 a general action programme with objectives and strategies for the period 1992-2010 was developed and adopted²¹. In 1992 a new comprehensive injury surveillance system for Falköping was introduced, based on national standards²². The programme has also been extended to encompass intentional injuries.

The following implementation and strategy/evaluation recommendations have been developed and published in the Local Intervention Programme Paper²³.

5.1.2 IMPLEMENTATION AND STRATEGY

Based on the experiences and outcomes of the Falköping study and the good results achieved, the following best practice method can be recommended. It is important that accident-prevention plans and the points of view of the reference group are well established with officials and politicians in the decision-making process.

Implementation

- 1 Epidemiological mapping (extension of accidents)
- 2 Selection of risk-groups and environments
- 3 Creation of an intersectoral reference group with different work groups
- 4 Joint planning of intervention programme
- 5 Management of intervention programme
- 6 Evaluation of intervention programme
- 7 Modification of intervention programme
- 8 Relying of experiences to others

²¹ Ekman R./Holmberg A./Teghammer-Holm S.: Intervention program 1992-2010. For improved safety for people of all ages in all environments and situations; 1992

²² Swedish National Board of Health and Welfare. Classification of unintentional injuries 1989. Stockholm 1989

²³ Ekman R./Holmberg A./Teghammer-Holm S.: Intervention program 1992-2010. For improved safety for people of all ages in all environments and situations; 1992

Strategy

- 1 Information/advice
- 2 Education/ training
- 3 Supervision/ surveillance
- 4 Product improvement/ control and environmental change

5.1.3. FOLLOWING UP/EVALUATION

The overall aim is to attain general knowledge of different methods to realize the goals ("to increase the number of accidents in order to achieve a reduction in their medical, psychological, social and economic consequences").

The evaluation efforts should be restricted to six main fields

1. **Input analysis**
What has been put in to achieve the aim of the programme?
2. **Output analysis**
Has this input had any effect within chosen fields?
3. **Process analysis**
Through which series of events are inputs related to the effects?
4. **Achievements of goal analysis**
Which are the goals of the programme and have they been achieved?
5. **Causal analysis**
Which factors promoted and which hindered the achievements of the goals?
6. **Efficiency analysis**
Could an acceptable degree of achievement of the goals have been realized in a more efficient manner?

The Falköping intervention programme is continuously reviewed according to new experiences and knowledge. The work group is preparing annual reports.

So far the reference group estimates a reduction in accidents of 10 to 20% for the period 1992 to 1994²⁴.

5.1.4. CHOICE OF INTERVENTION MEASURES

A municipality with a safety promotion "tradition" like Falköping has certainly a wide range of actual intervention measures to offer.

As it is just impossible to present even only a small amount of them we have to content ourselves with what can be estimated as one of the most successful projects. It is also a very good example of one intervention measure covering almost all risk areas.

The Hazard Hot-Line Falköping - OFALIA

The municipality is obliged to provide good service to its residents, which includes offering a community that is as safe and secure as possible. To avoid human suffering and also to reduce costs borne by the community, it is a matter of urgency that measures are taken against hazards before accidents occur.

²⁴ Ekman R./Holmberg A./Tegnhammer-Holm S.: Intervention program 1992-2010. For improved safety for people of all ages in all environments and situations; 1992

Whenever an accident is spotted by an Falköping inhabitant, she/he is encouraged to call the OFALIA line and report about it. Trained personnel is answering to the call and will fill in a specially-designed reporting form.

A copy of this form and an accompanying letter will be sent to the office, authority (street department, other municipal departments, the police, the national road administration) or individual responsible for the area concerned, asking them to remedy the stated defect.

As soon as appropriate measures are taken, this copy has to be sent back to OFALIA explaining the changes that were made.

The data enters into a statistical programme, providing opportunities for a following-up. This means that in follow-up reports OFALIA produces a list of all reported hazards that are older than three months and against which no measures have been taken. A reminder is then sent to the person in charge, stating that OFALIA requires information on what action the report has generated or will generate.

In total action has been taken in 75 % of the cases.

- ☞ **OFALIA receives reports on accident hazards**
- ☞ **OFALIA relays the report to the person/authority in charge**
- ☞ **OFALIA prevents accidents and injuries in just this way**
- ☞ **OFALIA then checks up what happened to the report**
- ☞ **OFALIA thus reduces unnecessary suffering and costs to the society**

5.2. WANG KHOI, THAILAND

Wang Khoi is a small village in the central part of Northern Thailand which was founded in 1961 when the Government of Thailand offered free land in this area and the first families moved in. Although the move toward the development of a primary health care system in Thailand started in 1978 it was not until 1981 that Wang Khoi was included in the rural development plan and the poor infrastructure was improved. In 1985 the WHO negotiated for the Thai government to be involved in pilot projects for the Health for All initiative. Later that year under the guidance of the Ministry of Public Health, Mahidol University and WHO Thailand, a steering committee was formed. The primary health care programme for Wang Khoi was developed as part of a wider programme in Nakonsawan Province which developed a system of education and training for health officers and workers, the selection and recruitment of village health volunteers and communicators, activation of the village committee, education and information for the villagers, technical and moral support and supervision.

Wang Khoi was designated as "Safe Community" in 1989, it played a leading role in monitoring the programme as it was the first demonstration object together with Lidköping, Sweden and still remains the only designated community in Asia.

While in industrialized countries organizing a cross-sectoral group and identifying priority areas is a case of mobilising existing public sectors, in a developing community like Wang Khoi the mere formation of an independent village committee constituted challenge for all the inhabitants.

5.2.1. ORGANIZATION

As mentioned above, the community-based safety promotion programme is embedded in a whole context of community-based politics and a striving for decentralisation.

In 1986 a village meeting was organized by a group of inhabitants to motivate and persuade people to understand the benefits of participatory efforts and to discuss their possible organisation.

As a result, villagers agreed to elect a village committee by nominating and selecting a representative from their residential cluster; this committee replaced the one which had been appointed by the Tambon chief and the district officials.

The new village committee brought their ideas about a Public Health approach to discussion on village development actions. This resulted in a plan of action elaborated by members of the committee and volunteers for each cluster. One of the programmes is the Accident Prevention Programme which started in 1989.

Related government sectoral representatives were requested to assist in collaborating with the private sector; especially the business sections responsible for purchasing farming machinery, fertilizer and insecticides, including representatives from

- Agriculture organizations
- Drug and food control
- Traffic and law enforcement
- Schools

The Village Development Fund

Villagers contribute to the Village Development Fund Scheme and become each a shareholding member. The funds are intended to be used as an investment tool and its profits and interests are taken to provide essential health services. The one responsible for the funds is the village committee, officials are only acting as consultants or resource persons in order to avoid top-down imposition.

5.2.2. CHOICE OF INTERVENTION MEASURES

As Wang Khoi had a zero starting point, its projects and activities differ a great way from those of the communities in industrialised countries and emphasis is put on the people's education in every field of daily life and on the strengthening of the community itself.

Information and Education

Objectives: Teaching people about existing hazards and how to avoid them; improving the community's knowledge about safety promotion in a very broad perspective.

Measures:

- the village policemen talked about traffic prevention and traffic rules, as the village knew a great traffic risk, due to the new built road leading to a high speed level
- an agricultural expert talked about prevention of pesticide poisoning as well as how to handle machines
- the teacher is responsible for road safety, electrical safety, and poisoning prevention for the schoolchildren.

Campaigns for Environmental Changes

Objective: In order to change the traffic environment the village committee decided to start with a slogan campaign.

Measures: Groups of ten households were asked to create a slogan which would be posted on hoarding places along the main road. The signs concerned drinking and driving, traffic rules and

speed limits.

Other campaigns included the reflector sticker campaign (any motor-vehicle should have a reflector) and a pedestrian safety campaign.

Prevention of Alcohol Related Problems Association of Thailand (P.A.P.A.)

The problems caused by alcohol are getting more and more serious in Thailand, resulting in an increase of road accidents. This is why the P.A.P.A. association was set up.

Objectives: To study and research alcohol related problems and to support the public education and training:

Measures: Distribution of pamphlets (REDUCE-REFUSE-QUIT) and broadcasting the campaign on TV and radio.

5.3. CORKERHILL, GREAT BRITAIN

"It may seem a curious contradiction to seek to have Corkerhill as a 'Safe Community' with all its evident problems of dampness and related ill-health, lack of amenities and safe-play areas for its 400 young persons under the age of 15 years....



Indeed it has been suggested by the cynics that Corkerhill might be more appropriately designated a 'disaster area'. However that would be to give up hope and turn to despair, rather than continue with our long held strategy of accident prevention, which tries to bring out the elimination of accidents at source...."²⁵

Corkerhill was once described as "A Model Railway Village" but today it is an area of deprivation. The village was established in 1896 by the Glasgow and South Western Railway company with a population of 700, mostly railwaymen, all transferred from Dumfrieshire. In 1987 (VPS) Corkerhill was a housing estate of 581 households and 1471 people, most of which are unemployed or work in very poorly paid, often part-time occupation.

The value of having Corkerhill as part of the Safe Communities Network is that the safety related activities of this community are genuinely community led. None of the members of the Community Council is paid for his or her work. In so far as professional organizations are involved, they have been brought in the community *by* the community, rather than the more normal community approach of professionals 'involving' community members.

One result of this is that Corkerhill works in a way which will be the case of many other unfunded communities and projects world-wide. Perhaps more than a well-funded project, or one with high political or officer input, it has to deal with many failures and disappointments as well as successes²⁶.

²⁵ Morrisson, W. et al : Corkerhill, Glasgow: Application to become a Member of the Safe Community Network, August 1992

²⁶ dito

5.3.1. ORGANIZATION

The Corkerhill Community Council was established in 1997 and, since its inception, has led the promotion of practical 'participatory democracy, whereby every constituent above sixteen can stand as a candidate for the 18 core seats on the Community Council.

Matters arising from injury are normally channelled through the Community Council by members and residents who work with the appropriate departments in an attempt to ensure that any risks are reduced or eliminated.

"Sub-groups" are encouraged from the outset to work towards autonomy. Thus, for example the Child Care and Safety Group set up to attract children away from danger and into safe play soon became independent with the representation on the Community Council, which all local groups enjoy.

Furthermore, the Corkerhill Community is in association with the Public Health Research Unit at Glasgow University and the Department of Geography at Edinburgh University, thus ensuring a scientific support.

5.3.2. CHOICE OF INTERVENTION MEASURES

The programme activities in Corkerhill aiming at promoting safety have a strong emphasis on environment and social structural issues and permanent change more than specifically educational and specific for some age groups.

Environmental conservation

In terms of Environmental Conservation, the Community Council not only organized Clean-Up Campaigns, together with BP Shell and others in the local woodlands, but were instrumental in launching the very first 'Landwise Backcourt Improvement Project" as well as creating a job campaign in Corkerhill in 1987.

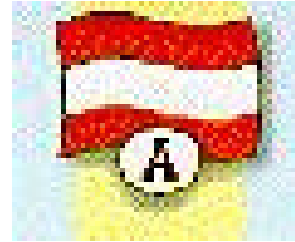
Subsequent to a survey of all tenants living in tenements with flat roofs in 1988, 300 individual letters complaining about dampness, mould growth, and chemical treatments. The Community Council decided to organize its own "Dampness Effect Public Enquiry". Subsequently the use of certain chemicals was stopped by Glasgow District Council. The Meeting agreed that a "Code of Practice" was essential and that the chemical substances still in use should be investigated.

Drugs/solvent and needle abuse

With regards to careless disposal of used needles, after a number of needlestick incidents including very young children, the efforts of the Community Council brought about the new emergency up-lift service, by Glasgow District Council's Environmental department.

5.4. VORARLBERG, AUSTRIA

The 14 villages forming the “Safe Community of Vorarlberg” are situated in the very north-east of Austria, at the Swiss-German border. Tourism has become a major economy-branch in this traditionally wood-working and cloth-spinning part of the country. Although Bregenz, the province’s capital (home of the famous Bregenz Festival) and part of the “Safe Communities”, is more of a major city than a village, the rest of the project region’s feature is clearly quite calm and rural.



Until 1994 no Austrian Community could be found in the WHO Safe Community Network and the “Sichere Gemeinde” Initiative with its project region in Vorarlberg still remains the only one in the country of Austria.

The province of Vorarlberg indicated its interest in a “Safe Community” project back in 1990, when the idea was first mooted by the “Sicher Leben Institut”. During the following years, the Vorarlberg Provincial Government and “Sicher Leben” were therefore looking for partners to assist in the implementation of an injury prevention strategy. Finally, fourteen communities around the city of Bregenz were involved in a three-year pilot project and they still form the core of the now extending programme.

The population rate of the project region (63 000 inhabitants) sums up to 0.82% of the Austrian population and 10% of the population of the province of Vorarlberg.

5.4.1. ORGANIZATION

A project team has been established in the region, forming a bridge between the local population and the local actors on the one hand, and the authorities and professional injury prevention institutions on the other.

The task of the project team is to provide potential organizers with the required specialized information, to encourage them to undertake their own activities, to put forward suggestions and provide organizational support. The commitment and performance of the project team is a significant factor in the successful creation of a local network for injury prevention.

Specific injury prevention measures should, in the first instance, be organized as local programmes by local organizations (e.g. schools, health and social security agencies, emergency rescue organizations, civil defence association, private-sector associations, local authorities, etc). All these organizations provide specialized communication channels for contacting their members or clients and are thus able to accomplish injury prevention at least as a secondary task (e.g. within the school curricula). Most of them also have a greater or lesser stake in injury prevention and a high sense of responsibility for family, children or the community.

Since safety promotion is a highly favoured subject within the community, activities in this field could even add to the initiator’s image account.

If no local organization could be found to meet certain main risk areas, various injury prevention institutions’ professionals became active to fill in this gap (the province of Vorarlberg, the community council, the General Accident Insurance, the Austrian Road Safety Board, the “Safety Living” (Sicher Leben) Institute , the Farmers’ Social Insurance)

The Financing Fund

Since it appeared difficult to determine any precise distribution of the benefits between the parties affected by injury-related costs (and therefore the ones to benefit from the programmes's outcome: savings in injury-related costs), the major project partners (municipalities, the province of Vorarlberg, health insurance, private sector insurance industry, accident insurance) contribute approximately equal funds to the project funds.

5.4.2. EVALUATION

One of the initiative's most **important aims was to raise the population's awareness about injuries, injury consequences and injury prevention**; as one of the conditions for successful interventions is to raise awareness to a level where people feel the need for acting *because* of this certain basic knowledge they have achieved, and which enables them to draw the right consequences.

The awareness raising was achieved by seminars, lectures and other activities ("Be-a-part activities"), and was backed-up by media work. This was important for both pushing the population to participate in the activities by documenting them and recalling dates and places, as well as informing about the risks and prevention measures themselves by publishing articles about injury prevention.

An on-going evaluation study was conducted for measuring the project's outcome: injury decreases and changes in knowledge and actions.

Evaluation data resources:

a) Documentation about the activities

Stating the fact that some persons have surely attended more than one activity, it can be assumed that all in all, over 15,000 people from the fourteen "Safe Community" villages have participated in one or more of the programmes initiatives, this sums up to a quarter of the project region's entire population.

b) Media appearance

Everybody over fourteen in the province of Vorarlberg had the opportunity to inform himself about safety promotion through the media, nine times through radio/TV and another 95 times through the print media.

Although there is no doubt that the quality of the contact is better when people participate directly in one of the activities, the media broad-casting must not be underestimated; a wider population could be reached, even outside the project region and also those who, initially, might not have been interested in the subject at all.

c) Survey about the level of knowledge and injury preventing behaviour

In 1994 a first survey was conducted in the whole country of Austria, backed up by a second survey among 200 Safe Communities inhabitants in 1996. The expected increase in the level of knowledge was indeed significantly, as for the injury preventing behaviour an increase could be noticed as well, although not big enough to be called significantly²⁷.

d) Household research

A household survey was conducted four times during the pilot phase (1993-1996). The first one was used to record the injuries occurring in the "Safe Community" villages and those in a parallel control region. A total number of approximately 3,500 incidences were covered in the project region and elsewhere in Vorarlberg thus providing a comparable numbers for both groups.

²⁷ table 4, p.24, Die Initiative Sichere Gemeinden, 1997

In 1994 and 1995 the surveys were conducted only in the experimental region, in 1996 again in both the experimental and control regions.

The overall injury risk in the Safe Communities decreased about 18% between 1993 and 1996, the most significant number can be seen in the sports (-22%) and leisure (-24%) area.

Amazingly enough, the decrease was even higher in the rest of Vorarlberg (-20%) which leads us to the conclusion, that the media did play a major role indeed, as it could reach everybody in the province and not only the "Safe Community" inhabitants.

Since the injury risk stayed almost stable in the rest of Austria, the decrease in the Safe Communities and the province of Vorarlberg, can be seen as a success due to the initiative²⁸.

5.4.3. CHOICE OF INTERVENTION MEASURES

The programme put strong emphasis on unintentional injury prevention, only one activity was related to intentional injury prevention (self-defence seminar), which is typical for project communities in rural areas.

The range of activities covered the major risk areas sport injuries, traffic injuries and injuries at home and at work.

Burn Injuries Prevention

Objectives: the population gets to know the Fire Brigade and their working tools, receives broader knowledge about fire prevention and fire fighting and about first aid in case of burn injuries

Measures:

- fire prevention as a major education theme in kindergarten
- "open doors" at the local Fire Brigade, community party with demonstration and information
- household check-up: how to use the fire extinguisher correctly, when to install a new one etc. burn injuries first aid seminars

Poisoning Prevention

Objectives: children learn about the plants in their environment, which ones are poisonous and which ones are not. Proud about their new knowledge, they are likely to tell their parents and brothers and sisters what they have learned, and will thus act as multipliers.

Measures: a walk in the close surroundings, guided by an expert (teacher, biologist), who explains the different plants, their characteristics and how to distinguish them.

Injury Prevention for Woodworkers and Do-it-yourself Workers

Objectives: to improve the knowledge about the working tools used (stressing, of course, the safety aspect), possible measures to be taken (e.g. helmets, eye-protection) and how to prevent injuries

Measures: professionals demonstrate their equipment and explain the right use. After the demonstration part the participants should have the opportunity to try out for themselves under the given professional supervision

²⁸p. 28 ff, Die Initiative Sichere Gemeinde, 1997

Leisure Injury Prevention

Objectives: to reduce the number of sport injuries, especially among the young people, due to risky behaviour and bad equipment

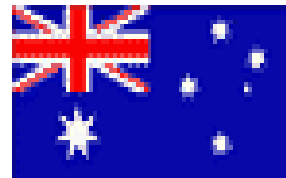
Measures:

- free introduction to the "art of snowboarding and inline-skating without coming home two ankles broken" by professionals with special emphasis on the right use of protection clothes.
- Fair-play football tournaments, the winner is not necessarily the one with the highest score of goals...

5.5. LATROBE VALLEY, AUSTRALIA

The municipality of La Trobe Shire (established in December 1994) encompasses the former Cities of Moe, Morwell and the City and Shire of Traralgon. The Shire is located in Victoria, approximately 135 kilometres east of Melbourne.

Keeping in mind the fact that the age group under 20 is the one facing the highest injury risk, it is evident that a community, where 32% of the inhabitants can be grouped as minors, has a major stake in implementing an injury prevention programme.



The period in which the programme operated coincided with massive social, economic and structural change in the region.

The brown coal based energy business saw significant restructure resulting in increased job dislocation and redundancies and the amalgamation of four local government authorities into one caused massive service reorientation.

One of the consequences for example the reorganisation of originally four different community health services along with the restructuring of other primary health care services such as hospital facilities.

5.5.1. ORGANIZATION

The **Latrobe Valley Better Health Project (LVBHP)** was established in 1992 with funds provided by the Victorian Health Promotion Foundation under the National Better Health Programme. It consisted of an Improved Nutrition and an Injury Prevention programme in order to address the two major health concerns in the local population.

A local management committee, representing a diverse group of Government, Local Government, industry and health agencies, was overseeing the programmes. The structure incorporated separate, issue specific, reference groups and working parties which worked towards achieving the specific objectives of the project.

The injury prevention component of LVBHP reassessed its goals and objectives during 1993. It was decided the programme would be better placed strategically if it reflected the objectives of the WHO Safe Community Network. Consequently, in 1994 the programme was renamed "La Trobe Safe Communities" and was accredited by the network in February 1996.

In July 1996, La Trobe Safe Communities moved into the structure of La Trobe Shire Council to continue the programme within a strategically relevant community agency.

5.5.2. EVALUATION

A programme evaluation has been conducted by the Affiliate Safe Community Support Centre at the Monash University Accident Research Centre; the results and findings were published in a Monash University report²⁹.

METHODS

The evaluation was a **quasi-experimental uncontrolled design** which included pre and post intervention observations. There was no single comparison community in which a range of equivalent measures had been recorded due to budgetary constraints. However, where possible, comparative data from a range of sources had been included. The evaluation covered the period from May 1992 to June 1996. The following recognised phases of evaluation were included: process, impact and outcome.

Data for process evaluation was obtained from programme reports, the programme officer's diaries and media file, and through interviews and discussions with key individuals from other local organisations.

The major method utilised for the impact evaluation was random household telephone surveying. Two surveys of 1.5% of the total population were conducted in April 1992 and April 1995, in conjunction with the Centre for Health, Education and Social Sciences (Monash University, Gippsland). The questions were designed to determine changes in knowledge, attitudes and practices and were modelled on questionnaires developed for the evaluation of a similar community-based injury prevention programme. Differences between responses in the pre-and post-intervention surveys were tested using the chi-square function in Excel.

Outcome evaluation was intended to include three sources of injury data: *self-reported injury, emergency department presentations and hospital admissions*. However, hospital admissions data presented significant methodological difficulties and was therefore not used. This had a significant disadvantage for the evaluation, since the hospital admissions data did not provide a similar opportunity.

- Self-reported injury data was gathered in the random household telephone surveys. Injury rates for the two week period were calculated using the total population surveyed as the denominator.
- Emergency department presentations data for five years (1991/92 - 1995/96) was obtained through the Victorian Injury Surveillance System (VISS) operating at both campuses of the Latrobe Regional Hospital, the only public hospital within the relatively well defined geographic area of the Latrobe Valley. VISS captures high known proportions of patients who were presented with an acute injury to the emergency department. There were no emergency department surveillance data for a comparable time period available for any other Victorian non-metropolitan region which could be used for comparison.

Data for targeted and untargeted injury categories were extracted by age group, for those residing in programme post code areas. The untargeted injury category served as a type of comparison since it encompassed injury not targeted by the programme or by other sectors (such as transport and occupational injury). Injury frequencies were adjusted for annual capture rates at each campus of the hospital. Injury rates per 100,000 population were calculated using the Australian Bureau of Statistics resident population estimates and were age standardized by the direct method to the Victorian population.

²⁹ Latrobe Valley Better Health Project- Evaluation of Injury Prevention Programme 1992-1996; Monash University Accident Research Centre, 1997

Two other sources of outcome data were used to evaluate the programme component relating to alcohol misuse among the youth. Data for fatal and serious casualty crashes among those up to 25 years of age for the programme region and comparison regions in rural Victoria were extracted from the VicRoads Crash Database for the years 1984-1995. The data used were limited to high alcohol hours, periods during which fatal and serious casualty crashes are 7 times more likely to involve blood alcohol contents exceeding 0.05%. Drunk and disorderly arrests by age, sex and postcode of residence were collected by the Victorian police regional headquarters.

Cost per injury prevented was calculated from the total direct programme costs and an estimate of the number of injuries prevented, assuming that the injury rate would have remained constant at the pre-programme level, in the absence of the programme.

5.5.3. CHOICE OF INTERVENTION MEASURES

Home Safety

Objectives: to familiarize the community with home safety measures and items and to reduce the incidence of child injuries by providing a venue where Safety promotion devices can be demonstrated to the public.

Measures

- ☞ home safety display house, featuring over 50 safety criteria, open for inspection for approximately 8 weeks
- ☞ home safety checklists
- ☞ extensive media coverage of home safety display
- ☞ Falls Prevention campaign
- ☞ housing, accommodation and community agency collaboration

Playground Safety

Objective: to reduce the number of injuries sustained by young children whilst using playground equipment.

Measures

- ☞ Soft fall material maintenance and equipment replacement in municipal playgrounds
- ☞ Municipal playground improvement strategy
- ☞ Commercial and institutional playground safety improvements

Alcohol Action

Objective: to reduce harm associated with alcohol misuse by young people

Measures

- ☞ initial "Responsible Serving of Alcohol" course
- ☞ collaboration with drug education in schools
- ☞ focus on light alcohol promotion in conjunction with "Play Safe Sport" sponsorship collaboration with Gippsland Anti-Violence Project

RESULTS

The evaluation revealed for the **targeted prevention areas**, a 28% rate reduction in unintentional home injury presentations, a 22% reduction in playground injury presentations and a 27% reduction in intentional injury presentations for the age group 10-24 year old.

Four key informant interviews were conducted to determine the **extent to which the project has been successful in forming strategic links with local organizations.**

It was clear from the interviews that the programme has built strategic partnerships with local organizations and that these partnerships have resulted in an increased emphasis on safety by the organizations themselves. The programme also facilitated interaction between agencies and individuals who had previously not interacted or co-ordinated their activities. However, given the indications that the programme officer was a critical driving force in achieving these outcomes, it is unclear the extent to which safety would continued to be pursued by local organizations without continual support and guidance.

5.6. DALLAS, UNITED STATES OF AMERICA

The city of Dallas is the eighth largest city in the U.S., and is made up of the majority of Dallas County's population. The ethnic background of the area, as reported in the 1990 U.S. census, is 61%Anglo, 18% African American, 18% Hispanic and 3% other cultures.



Severe injuries reached an all-time high in the Dallas County area during the summer of 1991. Already claimed to be the "most dangerous city in which to drive" in 1987 and experiencing a high rate of fire-arm deaths, the data obtained in 1991 showed that trauma was growing to such a precarious rate that the number of trauma patients would eventually outstrip the capacity of Dallas area Hospitals to treat them by 1995.

As part of the Dallas County Plan for a Comprehensive Trauma system, a panel of over 100 local experts and community leaders representing local governments, business, health and medical facilities, religious groups and other institutions examined this critical situation and developed a multi-year plan of action to address this problem to prevent injuries from occurring.

5.6.1. ORGANIZATION

The prevention component of this plan was the origin of the **Greater Dallas Injury Prevention Center (GDIPC)** which was created in 1994 as a center dedicated to using a scientific community-based approach to injury prevention:

The GDIPC provides the technical assistance necessary to create and help sustain effective, data-driven community based injury reduction efforts where non (or fledging ones) exist. It also serves as a national and international model for Safe Community programmes³⁰.

The region's Level 1 Trauma Center, Parkland Memorial Hospital, works closely with the University of Texas Southwestern Medical Center on a range of projects. The GDIPC builds on the long standing cooperative relationship between the two institutions.

Initial funding support was provided by local foundations.

5.6.2. CHOICE OF INTERVENTION MEASURES

Controlling traffic injuries in West Dallas

³⁰ Mission Statement as in the Biennial Report 96-97: The Making of a Safe Community; Greater Dallas Injury Prevention Center

In September 1996, the National Highway Traffic Safety Administration awarded GDIPC a three-year grant to develop a pilot traffic safety programme in Northwest Oak Cliff.

Objectives:

- to reduce motor vehicle crash-related injuries and high-risk behaviours that result in injury producing incidents
- to develop a model Safe Communities programme that other communities can replicate

Since receiving the grant, GDIPC has organized focus groups and conducted observational surveys to help identify assets and needs. Restraint use, particularly among children, within the targeted population is low. Coalition members, including representatives from Mothers Against Drunk Driving and the Dallas Police Department's *La Protectora* programme, have worked closely with residents to identify other important issues and to generate interest in addressing them.

Tactics have, thus far, included car-seat training, leadership training and educational presentations to children at community centres.

A unique aspect of this pilot project is the concentration on victims receiving follow-up care after their initial treatment. Lack of transportation often presents a barrier to rehabilitation services at Dallas' four major trauma facilities. About once a month, therefore, a trauma surgeon and rehabilitation physicians from the University of Texas Southwestern Medical Center will see trauma patients at the deHaro-Saldivar COPC Health Center in Northwest Oak Cliff. This should help prevent secondary complications and reduce the number of repeat injuries.

Don't Wreck Your Week

The Don't wreck your week coalition formed late in 1995, when the City of Dallas reported a 37 percent increase in motor-vehicle related deaths over the previous year. **Campaign activities were designed to draw attention to reckless driving habits and their consequences**, as well as issues and statistics related specifically to Dallas.

Motor vehicles crashes the week after the February 1996 campaign dropped 17 percent, the equivalent of a \approx 240,000 reduction in medical costs.

The 1997 campaign was 28th April through 5th May because of its proximity to high risk events such as graduations, proms and Cinco de Mayo. Formative research led the coalition to focus on three key areas of traffic safety:

1. Red-light running
2. Proper restraint use
3. Drunk driving

As with the 1996 campaign, the Dallas Police Department gave priority to enforcing laws related to the three target issues. Coalition members led education and awareness activities at churches, health fairs, Cinco de Mayo festivities, a Texas Instruments Earth Day observance and Dallas Love Field airport. Coalition volunteers also provided free car-seat inspections at various locations throughout Dallas.

Campaign billboards in English and Spanish reminded drivers "Red Still Means Stop". The coalition also developed and publicized maps illustrating Dallas' most hazardous intersections.

Child Abuse Prevention Coalition of Dallas (CAPCO)

The GDIPC co-ordinates CAPCO, a collaboration of individuals, agencies and

churches dedicated to preventing child abuse and neglect in Dallas.

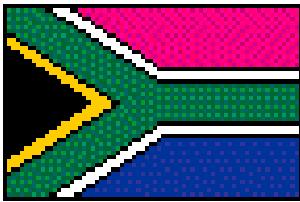
- the coalition has developed a guidebook and quarterly training programmes for members of religious organizations
- it serves as an advocate for child abuse-prevention issues and starts needed prevention interventions including fathering classes, a potty training coalition, judges training, a respite care coalition, and school-based parenting
- CAPCO spearheaded the effort to bring a Parent's Anonymous chapter to Dallas

Domestic Violence Awareness Coalition (DVAC)

- use of educational material, such as buttons, brochures and cards, to encourage victims of domestic violence to get help
- production of a video (in collaboration with the Presbyterian Healthcare Systems Video Communications department) for hospital workers about complying with reporting laws and standards from the Joint Commission on Accreditation of Healthcare Organizations

5.7. ELDORADO PARK, SOUTH AFRICA

In South Africa, the dominant injury cause is violence, much of which reflects the social pathology of existence in social and community settings where family and group bonds have



been destroyed or else have become so enmeshed as to lose all values as a source of safety and well-being for the individual. Despite increasing recognition that the prevention of such violence requires positive methods that go beyond the traditional responses of deterrence and incapacitation, there are few demonstration programmes that show alternatives³¹. The Safe Community at Eldorado Park is one of them.

5.7.1. ORGANIZATION

The Centre for Peace Action (CPA) is the single largest programme of the University of Africa's Health Psychology Unit which had started epidemiology studies about brain injury back in 1986.

Around the violence and injury prevention services delivered by the CPA (see table), the Health Psychology Unit was developing its portfolio of research and policy programmes aimed at developing injury prevention more generally. In 1994, its success in coupling the areas of service delivery and research led to the Unit's designation as a World Health Organization Collaborating Centre for Violence and Injury Prevention.

Centre for Peace Action Services

³¹ Butchart A./Seedat M: The Sixth International Conference on Safe Communities Report; KI Report 1998:1

INFORMATION MANAGEMENT AND RESEARCH					
& Services	Youth	Policing	Counselling	Business Development	Promotion Programmes
OUTREACH					

The CPA maintains two community-based safety promotion programmes. Both are structured used to define injury-producing settings, and design and implement interventions. The Three Neighbourhoods Safety Promotion Programme targets Rusthof and Nomzamo programme is based in three low-income settlements in the Western Cape.

policy changes at local and national government level, and to consolidating its role in the Johannesburg metropolitan structure.
of a national health and violence prevention plan, and in October 1997 was, along with the Greater Johannesburg Southern Metropolitan Structure, designated as the twenty first

32.

ELDORADO PARK

The epidemiological data on injuries collected during the late Eighties showed a number of Eldorado Park.

As it was impossible to fight a battle on three borders at once, the Health Psychology Unit Eldorado Park and in 1990 launched the "Eldorado Park Violence

Between May and October 1996, 1072 homes divided between six neighbourhoods in Eldorado neighbourhoods were two informal settlements (Slovo Park and housing areas (Extension 2 and Kersiedorp) and two council apartment blocks (Heathfield). The information of the survey was used to encourage the application of effective environmental interventions (which the community could not undertake on their own), and thus

The summary of this report is as below:

In the absence of any pre-existing data sources about injuries and the demographic characteristics of the area, a method was required which could produce both types of

First, large scale town planning maps were used to survey the area's spatial characteristics and mark out the different types of housing. These were council flats; council housing, and informal

investigate possible injury differences between similar neighbourhood types, two of each were

strategically selected as survey sites. A count of the exact number of dwellings within each neighbourhood was performed, and this was multiplied by the average number of residents per dwelling to generate a population figure for each area. The household was identified as the unit of investigation, and within each household was used as a proxy respondent for all other persons sharing the dwelling. Local persons were trained as interviewers, and worked in male-female pairs to enhance their safety.

Following pilot testing on a sample of 85 households, the final interview protocol included quantitative and qualitative questions investigating individual, social, communal, environmental and product-related risk factors for injury, as well as soliciting demographic data about all residents in each home sampled. The injury section asked respondents to describe all injuries that had been sustained by themselves and their co-residents over the past year, and in relation to violent injuries probed for extra information about victim-perpetrator relationship, weapons and products involved, etc. Ten percent of the sample was reinterviewed by an independent rater about the injury incidents they listed, to yield a highly satisfactory reliability.

Overall, violence was the single largest cause of injury, followed by traffic, and then non-violent home injuries. The injury profile differed substantially between neighbourhoods. The informal settlements were the most dangerous with total injury rates per 100 000 of around 15 000 per year, as compared to rates between 3 000 and 8 000 per year in the formal housing areas.

Recommendations

For **injuries due to traffic**, a variety of environmental modifications to high risk roads, and the provision of safe crossing points were the main interventions recommended. For **fall injuries**, it was recommended that safety audits of apartment blocks, public spaces and school play areas were conducted to identify and then eliminate the risky features such as stair treads, stair and balcony railings, playground equipment and playground and playground surfaces. **Burn injuries** were mainly a problem in the informal settlements. While electrification and housing improvement was recommended to prevent burns, it also recognized that interim solutions in the shape of improved devices for cooking, heating and lightning should be made following a safety audit of those methods currently in use. **Violent injuries**, while the most prevalent, are also the most complex to prevent. It is noted that the substantially lower incidence of violence in the formal housing areas suggest that violence can be reduced through community stabilization and environmental upgrading. Possible interim prevention strategies are then discussed, including the installation of street lightning, controls over alcohol sales, properly targeted visible policing, and the development of neighbourhood peer support groups to access victims and potential victims of violence by intimates and acquaintances, which occurs for the most part in private spaces beyond police control and is the most common form of violence across all areas.

As injuries due to both violent and non-intentional causes share common risk factors (e.g. alcohol abuse; poverty), the prevention of injuries due to unintentional causes may itself exert an appreciable effect on reducing violent injuries, therefore prevention strategies for these two types of causes are not mutually exclusive³³.

³³ Injury and Violence in Eldorado Park: a Neighbourhood Epidemiological Profile and Recommendations for Safety Promotion; report prepared by the CPA, submitted to the Greater Johannesburg Southern Metropolitan Structure; 1997

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