



KAROLINSKA INSTITUTET  
Department of Public Health Sciences  
*Division of Social Medicine*



WHO COLLABORATING CENTRE  
ON  
COMMUNITY SAFETY PROMOTION

# Application as an Affiliate Safe Community Support Centre

Centre for Peace Action, Institute for Social and  
Health Sciences, Johannesburg, South Africa

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# TABLE OF CONTENTS

- PART ONE..... 1**
- 1 BACKGROUND AND OVERVIEW..... 2**
  - 1.1 INTERNATIONAL EXCELLENCE ..... 2
  - 1.2 CONTEXT FOR KNOWLEDGE PRODUCTION: TERMS OF REFERENCE AND ASSUMPTIONS ..... 2
  - 1.3 ORIENTATION AND SCOPE ..... 3
- 2 MAGNITUDE OF INJURY PROBLEM AND RESEARCH GAPS..... 4**
  - 2.1 THEORETICAL FRAMEWORK ..... 6
- 3 OBJECTIVES..... 7**
  - 3.1 SPECIFIC OBJECTIVES..... 7
  - 3.2 SPECIFIC OBJECTIVES..... 9
  - 3.3 SPECIFIC..... 12
  - 3.4 SPECIFIC OBJECTIVES..... 13
- PART TWO..... 20**
- 4 BACKGROUND: THE CENTRE FOR PEACE ACTION: MISSION AND VISION ..... 21**
- 5 INTRODUCTION: THE SAFE COMMUNITY INDICATORS ..... 21**
- 6 ELDORADO PARK AND THE CENTRE FOR PEACE ACTION: A SAFE COMMUNITY? 22**
- 7 THE SAFE COMMUNITY INDICATORS RELATED TO THE CPA ..... 25**
  - 7.1 THE EXISTENCE OF A CROSS-SECTORAL GROUP RESPONSIBLE FOR INJURY PREVENTION ..... 25
  - 7.2 INVOLVEMENT OF THE LOCAL COMMUNITY NETWORK ..... 29
  - 7.3 A PROGRAMME COVERING ALL AGES, ENVIRONMENTS AND SITUATIONS ..... 30
  - 7.4 THE PROGRAMME MUST SHOW CONCERN FOR HIGH RISK GROUPS AND HIGH RISK ENVIRONMENTS AND AIM PARTICULARLY AT ENSURING JUSTICE FOR VULNERABLE GROUPS..... 32
  - 7.5 THOSE RESPONSIBLE MUST BE ABLE TO DOCUMENT THE FREQUENCY AND CAUSES OF INJURIES..... 32
  - 7.6 THE PROGRAMME MUST BE A LONG-TERM PROGRAMME RATHER THAN A SHORT-TERM PROJECT ..... 32
  - 7.7 UTILIZE APPROPRIATE INDICATORS TO EVALUATE PROCESSES AND THE EFFECTS OF CHANGE ..... 32
  - 7.8 ANALYSE THE COMMUNITY’S ORGANIZATIONS AND THEIR POSSIBILITY OF PARTICIPATION IN THE PROGRAMME..... 33
  - 7.9 INVOLVE THE HEALTH CARE ORGANISATION IN BOTH REGISTRATION OF INJURIES AND THE PREVENTION PROGRAMME..... 33
  - 7.10 BE PREPARED TO INVOLVE ALL LEVELS OF THE COMMUNITY IN SOLVING THE INJURY PROBLEM ..... 34
  - 7.11 DISSEMINATE EXPERIENCES BOTH NATIONALLY AND LOCALLY ..... 34
  - 7.12 BE PREPARED TO CONTRIBUTE TO A STRONG NETWORK OF SAFE COMMUNITIES ..... 35
- APPENDIX 1..... 36**
- METHODOLOGY ..... 37**
- A NEIGHBOURHOOD INJURY PROFILE..... 37**
- IMPLEMENTATION ..... 42**

<b>RECOMMENDATIONS FOR IMPROVING SAFETY .....</b>	<b>43</b>
<b>TRANSPORT RELATED INJURIES .....</b>	<b>43</b>
<b>NON-VIOLENT HOME INJURIES.....</b>	<b>45</b>
<b>VIOLENT INJURIES .....</b>	<b>46</b>
<b>CONCLUSION .....</b>	<b>47</b>
<b>REFERENCES.....</b>	<b>48</b>
<b>APPENDIX 2.....</b>	<b>49</b>
<b>PART THREE.....</b>	<b>50</b>

Earlier reports from WHO Collaborating Centre on Community Safety Promotion,  
Karolinska Institutet, Department of Public Health Sciences, Division of Social Medicine

# **PART ONE**

**INSTITUTE FOR SOCIAL  
AND HEALTH SCIENCES**

**STRATEGIC RESEARCH  
PROGRAMMING (2001 - 2005)**

**Note: This document also serves as an application for WHO Safe Communities Affiliate Status**

# 1 Background and Overview

The Unisa Institute for Social and Health Sciences (ISHS) endeavours to function as an internationally and locally recognized African research, service delivery, and educational centre of excellence within the social and health sciences, more specifically within the health and safety promotion fields, encouraging expertise in specific methodological, theoretical, policy and intervention areas.

The ISHS was formed in 1997 following a University of South Africa (Unisa) senate decision to combine the University's Institute for Behavioural Sciences (IBS) and its Health Psychology Unit (HPU) which include the Centre for Peace Action. Whereas the HPU was established in 1986, the IBS was created in 1974.

The Institute is a *WHO Collaborating Centre for Injury and Violence Prevention Research and Training*, and with the Johannesburg South West Metropolitan Council its Centre for Peace Action is part of the Global *WHO Safe Communities Network of Demonstration Programmes*.

## 1.1 International Excellence

While the primary focus of the Institute is on research that is effective in promoting health and safety within South Africa, all research is conducted with the African and broader international research community in mind. Existing collaborative links with research groups at institutions in the United States, Europe, Asia, South America and other parts of Africa (especially WHO, the US Centres for Disease Control, Sweden's Karolinska Institutet, the Indian Institute of Technology in New Delhi, the Uganda Injury Control Centre and the University of Rio de Janeiro in Brazil), are to be maintained and new links established to Africanize and ultimately internationalise the local research. An important mechanism in this regard is an international reference group to inform the Institute's work plans and offer suggestions around research implementation, future directions, and funding strategies.

## 1.2 Context for Knowledge Production: Terms of Reference and Assumptions

Despite the formalization of the various socio-health sciences and the associated technological advancements of the twentieth century, an audit of the human condition and global human development initiatives, raises questions about the role of science, in particular the socio-health sciences and their contribution to human advancement. While it would be grandiosely arrogant to assume that the socio-health sciences could have and can by themselves resolve all of humanity's massive concerns - such as poverty, uneven distribution of global resources, illiteracy, AIDS, violence, wars, nuclear armaments, child labour, cultural deracination, globalization and unbridled materialism - the socio-health sciences remain indicted on various counts. First, aside from their historical tacit and implicit complicity with dubious ideologies and corrosive socio-political systems, a large sector of the socio-health knowledge industry tends to be isolated and divorced from its socio-political and ecological contexts. The voices of enlightened theoreticians and many applied socio-health scientists tend to be marginalized by virtue of their peripheral positions in mainstream scientific establishments and difficulties with marshalling appropriate resources for socially relevant research. The *publish or perish* ethic together with the deeply entrenched individualistic ethic,

which sometimes borders on disregard for others, and the competition for scarce accoutrements within academia provides few incentives to restructure the socio-health sciences and their associated establishments. Second, attempts to reform the socio-health sciences remain embedded within the epistemological and philosophical traditions of the western ethno-sciences. Even though scholars studying the archaeology of knowledge production argue that science is a cultural product, methodological traditions and scientific products outside of the western ethno-sciences tend to be ignored and sometimes depicted as exotic artefacts that are to be stored as museum pieces. Third, the obsessive tendencies among certain socio-health scientists to uphold measurement, prediction and control as the “be all and end all” of science not only denies creative theoretical and methodological advancement and enquiry at the applied level, but also marginalises those scientists seeking to operate from a world-view that is other-than-western or secularized in its content, form, structure and philosophical base.

In defining and operationalizing its research programme, the Institute takes cognisance of this complex history of the socio-health sciences, and the associated enabling and disabling epistemological and methodological traditions; It seeks to document its own origins, history and evolutionary development, and uphold the principles of epistemological pluralism, methodological independence and open scientific enquiry. The Institute, as constituted by its people and its collaborating partners, endeavours to incorporate the research imperatives generated by its specific geographical location in Africa, and its relationship with the global socio-health scientific fraternity and institutions of knowledge production. The Institute’s researchers endeavour *to think globally but act locally* and thereby seek to contribute towards democratic forms of knowledge production, innovative theoretical development and the resolution of priority socio-health problems in the context of African democratisation initiatives and the wider calls for an African Renaissance. Due regard is therefore given to the principles of community participation and creation empowerment and prevailing indigenous systems of knowledge production and dissemination.

In its efforts to contribute to the restructuring of the social and health sciences and promote inclusive forms of theoretical and methodological development, the Institute also aims to remain mindful of its own organizational position within the institutions of knowledge production and wider socio-political systems, so as not to compromise its functions of critical thought and encouragement of independent academic engagement.

These challenging roles and functions which the Institute seeks to define for itself, require that its life-blood - its researchers and support staff - work to forge and develop a work ethic which embraces positive work values and the principles of accountability, honesty and open intellectual enquiry, intellectual humility, excellence and efficiency in task performance within all research, service delivery and teaching activities. The principles and values implied by these terms of reference give rise to and serve to inform the Institute’s mission, objectives, research programme and other operational aspects of its strategic plan (2001-2005). The reader is referred to Appendix 1 for details on the mission, vision and research objectives.

### **1.3 Orientation and Scope**

The ISHS operates through a mix of basic, strategic and service based action research, and has three broad focus strands which includes *injury epidemiology and surveillance, best practices for injury prevention and safety and health promotion, and secondary prevention and containment of injuries*.

Below we briefly describe the research activities associated with each of these three strands, and a fourth cross-cutting strand.

## 2 Magnitude of Injury Problem and Research gaps

Estimates project that by 2020 injury will rank ahead of all other causes except mental health as a contributor to disability adjusted life year (DALY) loss in low-income countries. This increase is projected to be particularly high in sub-Saharan Africa, owing to an excessive proportion of injuries due to wars, interpersonal violence (e.g. homicide, assault and rape) and motor vehicle crashes. In South Africa in 1999 the number of injury deaths was estimated to rank second only to AIDS deaths, and for economically active males aged 15 to 45 to account for some 70 percent of all mortality. Non-fatal injuries treated in state health care facilities were estimated to number 1.5 million per year, with a further 1.5 million seen by private health care services. For both fatal and non-fatal cases, interpersonal violence and transport related incidents were the predominant causes. The following insert is extracted from the executive summary of the report *Fatal Injuries in South Africa 1999* (prepared by the *National Injury Mortality Surveillance System*). It indicates the fatal tip of the South African violence and injury iceberg, and offers concrete examples of the problems that a best practice research programme is aimed at preventing.

“The NMSS is a mortuary-based system capturing 21 information items describing the “who, what, when, where and how” of fatal injuries. This report covers 1 January to 31 December 1999, during which 14 829 fatal injuries were registered at 10 mortuaries in five provinces. This is approximately 25% of the estimated 60 000 fatal injuries occurring for the whole country each year. The sample was biased to mainly urban areas, and the NMSS aims to progressively expand its geographical and case coverage until all injury deaths are included.

Manner of death. Homicide was the leading manner of death, accounting for 46% (N = 6 859) of all cases. Accidents accounted for 34% (N = 5 090), followed by suicide (8% or 1 157 cases). For 12% (N = 1 723) manner of death was undetermined. Males constituted 79% of all injury deaths, and there were 3.8 males for every female victim. The leading manner of death for males was homicide (51%) and for females, accidents (43%). The number of cases per month trended upward across the year for all manners of death except suicide.

External causes of death. Firearms overshadowed all other external causes, and accounted for 26% of all cases. The total of 3 906 firearm deaths was greater than the 3 684 deaths due to all motor vehicle accident (MVA) categories combined. From age 1 to 4 burns and pedestrian MVA deaths ranked first and second. From 5 to 14 years pedestrian injuries and drowning ranked first and second. From 15 to 64 firearms ranked first, and from 65 years on firearms and MVA pedestrians were approximately equal.

Homicide. Over half of the 6 859 homicides were inflicted by firearms, and a third by sharp instruments. The number of homicide victims rose abruptly in the 15 to 19 year age group and remained high until 39 years. There were 6.5 males per female homicide victim. Of the males, 51.7% were killed using firearms, while firearms accounted for 40.4% of female homicides. Strangulation homicides were over 6 times more frequent in females than in males. Strangulation and blunt instruments dominated up to 4 years of age, where after firearms and sharp instruments together accounted for around 80% of homicides per age group. Most homicides occurred in private homes, and nearly 80% of sharp instrument victims had positive blood alcohol contents (BAC) in contrast to the 40% of firearm victims with positive BACs.

Suicide. Firearms and hanging each accounted for one third of all 1 157 suicides. Most suicide victims were between 20 and 30 years of age. There were 3.5 males for every female suicide. The leading external causes of suicide in males were firearms (37.8%) and hanging (37.7%), and in females poisoning (29.9%) and firearms (26.0%). Most suicides occurred in

private homes, and 27 suicides were recorded as having occurred at or in places of custody. Under half of all suicide victims had elevated BACs.

Fatal accidents. Accident deaths due to transport, burns, falls and drowning, and other external causes accounted for 5 090 or 34% of all fatal injuries. Of these 77% were transport-related, 9% were due to burns, 5% due to drowning, and 8% due to other external causes.

Transport-related deaths. Of the 3 880 transport-related deaths, 92% were MVAs, 5% were railway-related and 3% involved cyclists. Pedestrians accounted for 39% of the MVAs, followed by 27% where the user category was unknown. There were 2.9 males per female transport-related death. Pedestrian deaths ranked as the top external cause of death from age 1 to 14 years, among the top three from 15 years onwards, and as the third leading cause across all ages. Most MVA-related deaths occurred from early afternoon to mid-evening on Fridays and weekends. BAC was positive for 65% of pedestrians and 53% of drivers.

Burns, falls, drowning and other accident deaths. Of the 1 169 deaths due to these causes, 41% were due to burns, 27% due to a cluster of 'other' accidents, 20% drowning, and 12% falls. Burns were the leading external cause of death under one year of age, and drowning ranked equal second with pedestrian deaths in this age group. Burns and drowning were the second and third leading external causes of death from 1 to 4 years of age, and drowning the second leading cause from 5 to 14 years. There were 4 males per female victim of drowning and falls, as against 1.5 males per female burn death. Most burn and fall deaths occurred in private homes, and drowning deaths in the sea, lakes and rivers, although a substantial proportion of drownings also happened in private homes. BACs were positive in 52% of the burn fatalities, 42% of the drowning deaths and 28% of the falls. There were 318 fatal accidents due to 'other' causes. In adults, contact with blunt objects (e.g. falling masonry) and crushing (mostly in mine accidents) were among the leading causes. In infants and children choking and poisoning by ingestion (e.g. of paraffin) were prominent.

Other fatal accidents. There were 349 fatal accidents due to 'other' causes. In adults, contact with blunt objects (e.g. falling masonry) and crushing (mostly in mine accidents) were among the leading causes. In infants and children choking and poisoning by ingestion (e.g. of paraffin) were prominent.

Manner of death undetermined. The age distribution of the 1 723 deaths where the manner was undetermined showed a concentration of cases among the very young (0 to 4) and the elderly (65 years and over). For deaths between these age groups the pattern by victim age and seasonal trend for deaths where the manner was undetermined was similar to that for suicides.

Despite this growing recognition of injuries as a priority public health concern in South Africa and on the rest of the continent, our social and scientific responses and investment in their prevention remains inadequate. In addition to the various institutional obstacles, three primary factors tend to undermine the primary prevention and injury control response on the continent. Firstly, the unavailability of reliable national and continental level data on the extent and patterns of injury mortality and morbidity make it difficult to define the risks, determinants and costs of injury. Hence there is an urgent need for *quality Epidemiological and Surveillance Data*. Secondly, there is a lack of systematic studies on *Best Practices* to primary prevention in many low to middle income countries including South Africa on the continent. We know very little about what works in primary prevention in Africa and at what costs. Thirdly, there is also little knowledge about *Best Practices* for the effective *Secondary Prevention* of injuries and associated psychosocial trauma.

The need for information on the patterns, risks and determinants of injury and how to prevent injuries and promote safety is therefore growing rapidly. In seeking to address this need we follow the public health logic assumed by other successful prevention work and which promotes the idea that safety promotion is contingent on problem definition, risk factor identification, development and testing of pilot programmes and implementation and on-going measurement of effectiveness.

Within the field of injury prevention and safety/health promotion, our Institute's overall goal is to produce research on the causes, consequences and costs of injuries and best practices for primary and secondary injury prevention and safety promotion. The emergent body of knowledge is to be used strategically to develop the Institute into a continental and eventually an international centre of excellence that serves as a resource for research groups, service agencies and policy makers working in the field of safety and health promotion and more specifically in violence prevention.

## **2.1 Theoretical Framework**

The Institute's injury research is primarily conceptualised around the four-stage public health approach to violence and injury prevention: (1) Problem definition; (2) Risk factor identification; (3) Development and testing of pilot prevention programmes; (4) Implementation of interventions and ongoing measurement of effectiveness. Within this approach, work within the different areas of investigation is guided by subject-specific theories, although the Institute's emphasis on research for primary and secondary prevention means that theories which highlight the social aetiology of violence and accidents and which help to identify policy-sensitive risk factors are favoured as may be appropriate. It should also be noted that whereas the *epidemiology and surveillance* strand converge around the first two stages of the PH approach, the *best practices* strand converges around the third and fourth stages, thereby promoting synergistic exchanges between the various research strands.

## 3 Objectives

The specific research objectives of the injury research programme are organized around three inter-related strands and a fourth crossing cutting strand. The *first strand* which represents a continuation of the historical and existing surveillance work includes *violence and injury epidemiology and surveillance* and risk factor identification research and additional areas of research examining the costs of injuries, and macro-social determinants of injuries. The *second strand* which represents a continuation of the Institute's Centre for Peace Action's community-based injury prevention work includes research on *best-practice examples for injury prevention and safety promotion* for low-to-middle contexts. The *third strand*, which also embodies a continuation of the Institute's and Centre's *Secondary Containment Initiative*, involves the study of *best practices* for the *secondary prevention of injuries* and associated psychic trauma. The *fourth cross-cutting strand*, focuses on information dissemination, conceptual development and capacity building.

<b>STRAND ONE</b> <b>Injury Epidemiology, Surveillance and Costs</b>
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### 3.1 Specific Objectives

The specific objectives of this strand are to:

- (1) Conduct and disseminate public health oriented research into the causes and consequences of injuries due to violence and accidents in South Africa; and
- (2) Demonstrate and document how the research findings can be used to influence health policy and planning with regard to the primary prevention of violence and injury.

The *core research areas* for the period 2001-2005 will represent a continuation of existing violence and injury surveillance and risk factor identification research, plus new areas of research examining the costs of injuries and macro-social determinants of injuries. The research portfolio will consist of four specific sub-areas.

1. **Injury Surveillance.** Sub-Area I is the continuing development and evaluation of the current national injury surveillance system, which includes a mortuary-based fatal injury component and a health-facility based non-fatal injury component. Research partners in this work include three Historically Black Universities (HBU's). A major aspect of the process will be securing funding for the programme on a more permanent basis. As well as local journal articles describing the system for South African participants and information users, a number of international articles that reflect on the South African experience and its implications for surveillance development in other middle- and low-income countries will be prepared on an on-going basis.
2. **Emerging Problems and Strategic Priorities.** Sub-Area II consists of topical studies on emerging problems identified through surveillance and strategically defined priorities. The objectives and duration of these studies may therefore change more rapidly than those in the other core sub-areas. Two strategic priorities that will be of immediate relevance to current policy debates around violence and injury prevention concern the victim-perpetrator relationship in cases of violence, and the prevention implications of alcohol and drug abuse patterns in injury victims.
  - (a) **Perpetrator-victim relationship patterns for fatal and non-fatal violence and the**

**precursors of lethal violence.** There are almost no South African studies that examine perpetrator-victim relationships, and perhaps none that scientifically investigate the precursors of lethal violence. The injury surveillance case registration forms have special fields in which to collect these data, from victims and/or caregivers for non-fatal violence, and from completed court proceedings lodged in the Criminal Record Centres for fatal cases. Pilot data for non-fatal cases from a few sites are already available, and information on the precursors of homicide and suicide from a thousands of court proceedings representing incidents occurring in seven provinces will also be potentially available in the near future.

- (b) **Prevention implications of the relationship between alcohol and drug use patterns by cause of injury, victim demographics and geographical location of incident.** An increasing body of published South African studies and a growing dataset from the emerging injury surveillance system demonstrate that victims of violence, motor vehicle crashes and some other accidents include a disproportionately high number that are intoxicated. While road user campaigns to prevent drunk driving seem useful in reducing the transport-related burden of alcohol and drug-related injuries, there is far less clarity about how the findings should be applied in the prevention of injuries due to violence and accidents in the home. These issues will be explored through qualitative investigations including interviews and focus group discussions with stakeholders in high-risk communities, the alcohol industry (formal and informal), and the police.
3. **Social Burden of Injury.** III examines the social burden of injury and potential health expenditure savings by injury prevention in South Africa. While this can be estimated in many ways, cost is the Rosetta stone that makes burden estimates understandable. The evolution of injury prevention responses in other societies suggests that, alongside surveillance, the capacity to measure the costs of injury is crucial to mobilising the political commitment required to institutionalise the legislative and budgetary supports underlying sustainable injury prevention programmes. Injury costing research is poorly developed in South Africa. This raises the possibility that progress in injury surveillance and risk factor identification may not find the level of transfer into preventive investments by the state and corporate sectors needed to achieve substantial safety gains at the population level. A consortium involving the Institute, MRC, University of Durban-Westville, University of Transkei, Red Cross Children's Hospital and the Karolinska Institute will examine the burden of injury in terms of: (1) Medical costs; (2) Labour loss costs; (3) Other social sector costs; (4) Human value costs. In essence, the methodology will involve establishing these costs for a sample of frequently occurring injury types, and then multiplying the results by the injury incidence in different populations (e.g. geographically or occupationally defined, by age and gender, etc.) in order to show the aggregate costs of injuries by sector. A policy process and impact assessment component is built into the research design, with the major targets for policy implementation being the state ministries that currently underwrite the injury surveillance programmes, that is, Health, Safety and Security, DACST, provincial and local government stakeholders, and the corporate sector. Special attention will be accorded to the possible misuses of injury cost data and so the ideological imperatives underlying injury costs studies.
4. **Macro-level Determinants of Violence and Injury.** Incidence rates for interpersonal violence and most accidental causes of injury are closely linked to a society's overall level of socio-economic development and to intra-social inequalities in gender, income distribution, social capital and other macro-level factors including state ideology. In addition, these factors may strongly condition the social potential for primary prevention. Sub-Area IV will therefore examine these macro-level determinants of violence and injury by analysing differences in injury incidence by cause over time and across provinces and communities within South Africa, and by comparing South Africa's injury profile to other

partially industrialized and developed countries.

<p style="text-align: center;"><b>STRAND TWO</b> <b>Best Practices Research: Injury Prevention, Evaluation and Costs</b></p>
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### 3.2 Specific Objectives

The specific objectives of this strand are to:

- (1) Conduct research that will serve to identify and support state-of-the-art best practices for primary injury prevention and safety promotion; and
- (2) Demonstrate and document how research may be applied to facilitate, influence, support, and develop best practices for primary injury prevention and safety promotion at the levels of service delivery, planning, and policy.

This strand will represent continuation of the Institute's community-based activities, including that of the Centre for Peace Action. This strand consists of five specific sub-areas: (1) of the development of safety promotion measures for specific vulnerable groups and priority injury problems; (2) identification of best practices; (3) evaluation and monitoring methodologies; and (4) safety-promotion costs.

#### **1. At Risk Groups and Priority Injuries**

This first sub-area is a continuing development of primary safety promotion measures for at risks groups (youth, abused women, child labourers, injured children) in low-income and marginalised communities. It includes the work of the Centre for Peace Action and involves researching the initiation, development and monitoring of a safe schools programme and a women's led safety promotion programme in several low-income and shack communities of Southern Johannesburg (e.g. Eldorado Park, Thembelihle) and in the Helderberg region of the Western Cape (e.g. Nomzamo, Erijaville and Tarentaal). By way of synergizing the concepts and principles of public health, community psychology and community development, this sub-area is designed to yield research on community-based strategies for reducing risk, promoting social assets and enhancing resiliency behaviours that are vital for containing secondary victimization and reducing the severity of injuries. Here we will also scrutinise the notion of a "risk personality" with a view to studying the possible associations between the risks for violence, sexual coercion and HIV/AIDS. Two emerging and priority areas that this sub-area will focus on include best practices for prevention of injuries in early childhood and occupational health and safety.

#### ***(a) Early Childhood Development and Safety***

Early childhood experiences in respect of nutrition, parenting, socialisation and disease exposure are critical to later well-being and a peaceful, happy and productive society. With strong preventive implications for violence, accidents, infectious diseases, substance abuse and many other health problems, the Institute's early childhood development research programme examines factors such as the risk for injuries, the determinants and effects of childhood peer relationships, and risk and protective factors for adolescent alienation.

### ***(b) Occupational Health and Safety***

Research supporting health and safety in the business, social service and state sectors is fundamental to promoting the good labour relations and employee well-being that sustain social capital and economic profitability. During 1997-1999 the Institute in partnership with the Gauteng Department of Health's directorate for Environmental and Occupational Health focused on research for safety promotion in two major but largely ignored sectors, the South African Police Services, and the informal business sector. Findings are used to improve occupational health and safety through top-down interventions involving policy and the enforcement of safety legislation, and bottom-up interventions that begin with at-risk individuals by training them to decrease the level of risk in their immediate environment.

### **2. Research Data, Community Action and Policy**

This second sub-area, as encapsulated in the Centre for Peace Action, also provides opportunity to research the processes, strategies and psychosocial, political and cultural dynamics involved in attempts to convert epidemiological and surveillance data into concrete action and policies for injury prevention and community safety. In short this sub-area will continue to research the relevance of those psycho-social, structural and organizational issues that emerge when research is used to mobilize marginalized communities and at-risk groups within them into action for the development of best practices for safety promotion. It will provide information on how to successfully (or how not to) initiate and implement long-term, cross-sectorial, community-led safety promotion programmes in low-income settings and inform or influence macro-level policy formulation.

### **3. Identification and Reinforcement of Best Practices for Safety Promotion**

This third sub-area focuses on the identification of best practices for the primary prevention of injury arising from interpersonal violence, traffic-related incidents, burns, falls and other "accidents" in the home among children and the elderly. This will be achieved through regular case studies, audits and assessments of existing primary prevention programmes (e.g. audit of women's violence prevention and development initiatives; youth violence prevention programmes). In addition the regular review of the grey, published and unpublished literature will be used to support the development of best practices and benchmarks for community safety promotion. Following the work of Murphy:

(<http://ww1.best4health.org/solutions/bestpractices/bpcomponents.cfm>) on the improvement of health care processes other outcomes of regular audits could include a description of:

- The basic professional, intellectual and technical competence required of safety promotion service providers in low-income contexts;
- Behaviours and practices indicating appreciation, recognition and responsiveness to the safety and associated human rights of marginalized groups and communities; and
- Organizational structures that assure punctuality in delivery of care, efficiency in executing processes and excellent adherence to protocols.

### **4. Evaluation and Monitoring Methods**

The focus here consists of developing evaluation designs and methods that are needed to assess programmatic replicability and the short and long-term impact and outcome of safety promotion interventions. This area will be logically extended to develop standards for the consistent application of evaluation methods and research the development of multiple

methods of evaluation that are eventually accessible to service providers and planners. The methods which could include -among others- longitudinal evaluation designs, and experimental designs, will ideally solicit both stakeholders opinions and statistical evidence to demonstrate success or failure of injury prevention and safety promotion interventions. Aside from assessing the costs and impact the evaluation research will aim to answer questions about replicability, cross-cultural generalizability, international acceptance, accessibility and affinity to WHO Safe Communities criteria. Whenever possible, the impact of social experiments (e.g. relocation of shack communities for safety) will also be evaluated.

Sub-Areas, 1, 2, 3 and 4 will ultimately also serve to complement the work of several WHO Collaborating Centres on Safety Promotion that are currently aiming “to develop a guide for the design and implementation of safety promotion programmes, including a checklist of issues one should consider before jumping into action”. (p.1, <http://www.ki.se/phs/wcc-csp/affproj2.html>). The Institute’s research will provide information on the “basic rules for program management and for linking evaluation research with intervention steps” (p.1, <http://www.ki.se/phs/wcc-csp/affproj2.html>) for low-income and southern contexts and thereby encourage further cross-cultural research.

### **5. Safety Promotion Costs**

In order to encourage evidence-based injury prevention and safety promotion, the Institute’s work in this core area focuses on producing research on the costs of interventions and policies. Information on the cost effectiveness of specific measures together with information on the relative costs-benefits of various approaches for safety promotion are vital for planning and selecting the most suitable approaches when resources for prevention are limited. Research on cost-benefits can ultimately be fed into the findings on injury-costing research to influence decisions about resource allocation and programming.

## **STRAND THREE**

### **Best practices Research: Secondary Prevention and Injury Containment**

The effective secondary prevention of injuries and associated psychic trauma reduces the disability burden in the population and thus contains health care costs. Such prevention requires effective treatment which in turn requires early and accurate diagnosis, and accessible, quality and culturally-appropriate services which includes pre-hospital care and emergency medical and post-traumatic psychosocial and medical treatment.

This strand represents a continuation of the Centre’s mental health and counselling services and earlier rape surveillance project and embraces three main sub-areas. The Institute has a strong knowledge base in this area, going back to its work in the 1980s which involved the development of appropriate diagnostic instruments for South African neuropsychologists.

### **3.3 Specific Objectives**

The specific objectives of this strand are to:

- (1) Conduct research that will serve to identify and support state-of-the-art best practices for secondary injury prevention and containment of psychological trauma; and
- (2) Demonstrate and document how research may be applied to facilitate, influence, support, and develop best practices for secondary injury prevention and containment at the levels of service delivery, planning, and policy.

### **1. Health Systems Research**

Despite philosophical and political commitment to restructuring health services, little is known about the extent, nature, distribution and impact of health and social services and in particular mental health delivery systems in South Africa. Through its health systems research, the Institute aims to provide data on the quality of services, including medical and psycho-social services for victims of violence and unintentional injuries. Among the more important goals are to stimulate state and provincial commitment to developing a national health surveillance system, and to inform policies in respect of funding, training and developing minimum standards for quality care for victims of violence. Data on client utilisation patterns, client profiles and perception of services is therefore vital.

A key component of this sub-area is a project *assessing the quality of care at Gauteng's Medico-Legal Services*. The current project was initiated in 2000 following recommendations that emerged from the ISHS's Rape Surveillance Project, which was conducted in collaboration with the Gauteng Health Department's Directorate of Medico-Legal Services from 1994 to 1998. The scope of the study includes an assessment of the structure, process and outcome of after-care services for rape victims at all the Medico-Legal centres in Gauteng, one of South Africa's nine provinces. Accordingly, the project will evaluate the *availability, accessibility, quantity, effectiveness and acceptability* of the services. Special attention will be given to the views of the service providers and rape survivors who use the Medico-Legal centres. The aim of the proposed evaluation is to ascertain the current status of Medico-Legal Services in Gauteng against the Health Department's stated objectives and various other stakeholders' views of how the service can and should function. Such an evaluation will serve to inform the development of quality services based on the principles of Best Practice. This project contains the potential of growing into a national endeavour.

### **2. Counselling and Mental Health Promotion**

Despite the ongoing demand for the provision of acute psychosocial services in low-to-middle income contexts, fiscal and human resource limitations, and cultural considerations continue to stymie the development of such services. The injury prevention movement's primary focus on physical injury also under values the necessity of mental-health services in the containment of psychic trauma. The Institute therefore through its own and other psychological services encourages critical research on the development of appropriate sustainable, cost-effective and replicable best practice mental health promotion approaches.

### **3. Pre and Post Hospital Care for Injury Victims**

Many people injured as a result of gunshots, landmine blasts in Africa and motor vehicle accidents often cannot easily access formal emergency medical and social services. Consequently those community members closest to or first upon the scene of injury or trauma -

known as first responders - often provide pre-hospital care for this group of victims. These first responders frequently also provide post-hospital care, assisting with rehabilitation and post-trauma counselling. Accordingly this sub-area focuses on understanding those pre-requisite conditions, communal arrangements and individual profiles that enable first responders to do what they do well. What kinds of *indigenous best practices* do first responders bring to secondary prevention including rehabilitation and how best may they be supported to render valuable care? These and other such questions frame the research focus in this sub-area.

<b>STRAND FOUR</b> <b>Information, Conceptual Development and Capacity Building</b>
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An information service, the development of conceptual and theoretical frameworks and capacity building crosscuts all three areas, detailed above. This strand includes three key strategic sub-areas that are designed to promote injury prevention research capacity and awareness on the African continent.

### **3.4 Specific Objectives**

The specific objectives of this cross-cutting strand to:

- (1) Build capacity for research on the causes and consequences of injuries arising from violence and accidents;
- (2) Build capacity for safety promotion and best practices research in injury prevention among South African and other marginalized groups on the continent; and
- (3) Increase use of injury research and best practices data at levels of service provision, policy formulation and training.

#### **1. Information service**

In line with its aims to serve as a continent level resource, this sub-area includes the continuation of the Institute's existing resource library and development of multiple techniques and multimedia methods (print, visual, electronic, oral) to disseminate research data and general information service and is run on a no-charge basis as far as possible. The service targets safety promotion researchers and practitioners, industry, media, policy-makers, health and allied professionals/administrators, donor agencies, community groups and individuals, relevant agencies of civil society and all sectors of government. Based on the concept of "share what works" (<http://ww1.best4health.org/solutions/index.cfm>) safety promotion researchers, administrators and practitioners can also participate in interactive exchange around seven kinds of activities. These activities are listed in Table 1 below.

**TABLE 1**

<b>RECOMMENDED BEST PRACTICE INTERNET NETWORK FOR INJURY PREVENTION/SAFETY PROMOTION</b>
<b>DISCUSSION SPACE</b> A discussion space where safety promotion professionals can post and respond to practical problems related to prevention in low-to-middle income contexts.
<b>EVERYDAY INNOVATIONS</b> A showcase of creative thinking and methodological skills applied to practical implementation issues in safety promotion.
<b>BEST PRACTICE INCUBATOR</b> An on-line workshop where <b>Best Practice</b> developers can post information about their projects in progress and request networking or mentoring support from our network participants.
<b>TOOLS OF THE TRADE</b> A collection of guidelines, norms, and standards for <b>Best Practice</b> in low-income contexts.
<b>PROGRAMMES THAT WORK</b> Fully-implemented projects that have positively influenced safety promotion, significantly improved operational efficiency and/or offered solutions to otherwise insurmountable problems.
<b>BEST PRACTICES</b> Fully-implemented programmes, benchmarked, tested and evaluated, which fulfil new standards and/or introduce outstanding innovations in safety promotion/injury prevention.

In addition information is distributed through several existing Institute publications which include a monograph series, a community report-back series, a research and technical report series and an occasional paper series. Recently the Institute and its CPA launched two safe communities newsletters that are distributed in South Africa and several other parts of the continent. *Learning groups* in the form of small focus group discussions, seminars, colloquia and workshops are encouraged especially in contexts *where there are no developed tele-communication systems or technologies*. The kinds of information that this core activity seeks to develop and disseminate include:

- Safety promotion and prevention practice guidelines;
- Strategies for the dissemination of workable Best Practices;
- Best management practices for safety promotion for different sub-regions of South Africa and the African continent as a whole;
- Best research practices for rapid programme evaluation;
- Best policy options for safety promotion in low-income settings;
- Customised reports that are prepared on requests from the research and service communities.

Within this core area the cost and relative benefits/impact of the various dissemination

methods are an important area of investigation especially as the Institute begins to consider ways of forging south-to-south partnerships.

## **2. Development of conceptual and theoretical frameworks**

Given the overwhelming northern orientation of current safety promotion theory which is ensconced in a particular view of society, science, knowledge and history, the ISHS also encourages the development of alternative theoretical and conceptual frameworks. Through social studies of medicine, health and development this sub-area encourages and examination of the implications of these disciplines for the individual and collective identities of their human subjects. Through historical and contemporary studies, the Institute's main focus here is on the critical analysis of the power and political dynamics produced by the interplay of western psychological and medical knowledge with indigenous African belief systems and philosophies. Accordingly ISHS aims to convene regularly a group comprising of African and southern-based injury prevention and safety promotion researchers who subscribe to the idea that theoretical development requires innovation, freedom of enquiry and multiple methods of research and who are open to indigenous knowledge systems and intuitive ways of knowing in theoretical building. Operating as a collective the group may be encouraged to produce theoretically-oriented writing on topics such as (1) globalisation of knowledge systems and implications for safety promotion theoretical development on the periphery; (2) globalisation and safety in peripheral and emerging economies; (3) the current state of knowledge in psychology and its contributions to safety promotion theory in the South; (4) anthropology and its study of indigenous knowledge systems and indigenous technologies: Lessons for safety promotion theory; (5) science, spirituality and safety promotion theory: implications for best practice; and (6) state, political economy and safety promotion theory. This list of topics is by no means exhaustive.

## **3. Capacity Development**

Capacity development is encouraged through three mechanisms:

1. The identification of research partners at HBU's and procurement of funding for joint research projects with the Institute (e.g. the national injury surveillance and injury costing programmes);
2. The employment of individuals from HBU's as research assistants, research interns, temporary researchers and permanent staff, where indicated and as appropriate to their qualifications;
3. The delivery of violence and injury prevention training courses and consultative inputs using the Institute's research output and targeting South Africans at tertiary research and teaching institutions, local, provincial and national government, and injury prevention workers from other African countries (e.g. Mozambique, Uganda, Kenya).

This sub-area also involves training masters and PhD. students (interns and practitioners etc.), authorship development initiatives and collaborative research projects. Targeting marginalized health promotion and public health workers/researchers in South Africa and the Southern African Region in particular, the training component includes among others courses on: (1) public health and social science methodologies for safety promotion; (2) quantitative methods in social sciences with a specific reference to safety promotion; (3) qualitative methods for designing, monitoring and evaluating safety promotion initiatives; (4) issues in

community-based approaches to prevention; and (5) traffic control and prevention. The Institute and its CPA are registered as internship sites with the South African Health Professional Council to provide training to research and counselling students.

While these courses and variations thereof are designed to foster intervention, research and evaluation skills among trainees who are drawn primarily from the various African Injury and Violence Prevention Networks, practical authorship development initiatives may also be implemented shortly. Given South Africa and the region's racist and gendered legacy it is necessary to ensure representivity at the level of production and dissemination of knowledge. Collaboration with research partners at HBU's, the employment of research interns, supervision of masters/PhD. students and networking with various continent-based injury prevention networks are among the many strategies that are used to enhance/develop safety promotion skills and transform the fledging field into a highly recognized professional area of expertise. Finally it must be noted that this sub-area also capacitates at risk communities and volunteer groups therein in injury prevention, safety promotion and other relevant organisational and project management skills.

## **Appendix 1**

### **Mission, Vision, and Research Objectives**

#### **Mission**

The mission of the Institute for Social and Health Sciences and its Centre for Peace Action is to:

- ❖ function as an internationally and locally recognized African research centre of excellence within the social and health sciences, promoting research and encouraging expertise in methodological, theoretical, policy and intervention areas.

#### **Vision**

Fundamental to the Institute's and the CPA's public health vision is the recognition of illness and suffering as produced by the micro- and macro-environments into which people are born, develop and die, and its activities are intended to stimulate individual and social responses aimed at changing the social, behavioural and environmental factors that cause suffering and illness. Accordingly, the Institute's focus is upon the individual not as the pre-given origin or end-point of pathological processes and actions, but on the behavioural tendencies of individuals and groups as an outcome of causal relationships to people (e.g. parents, peers), to products (e.g. guns, alcohol, pornography, media violence), and to environments (both physical and socio-cultural). Suffering and illness are thus cast in relational terms, and through research these risk factors can be identified and then manipulated to prevent the problem.

#### **Long Term Research and Service Delivery Objectives**

As a research enterprise the ISHS takes cognisance of its collective legacy and maintains multiple research foci. The research programme is designed to make for a stimulating academic context and increases the Institute's resilience to shifts in funding priorities often defined by essential global and national socio-health research needs. In addition, integrating this research expertise with the CPA's service delivery activities creates the opportunity to engage in service-based research aimed at developing, implementing, evaluating and documenting replicable models for violence and injury prevention in South Africa and low-income countries more generally. The long term research goals of the ISHS are therefore to:

1. Promote and encourage multi-disciplinary and cross-sectoral research in the social and health sciences through service delivery and other avenues with reference to specific areas including injury prevention, early childhood development, occupational health and safety, cognitive neuropsychology, safety promotion, child labour, sociology of health and development, methodology development, sociology of knowledge production and public health phenomena such as violence and HIV/AIDS;
2. Develop methods by which the primary causes of injuries and related psychological distress can be identified and described, and to articulate at a theoretical and conceptual level the implications of these causes for public health interventions, community and research psychology, and the promotion of health for all;

3. Encourage the scientific development of transferable solutions and delivery models for priority psychosocial and health problems (e.g. gunshot injuries, alcohol related violence, school dropout, sexual violence in adolescent relationships, adversity in early childhood relationships);
4. Initiate practical interventions aimed at operationalising, evaluating and refining such solutions and models;
5. Shift the focus within the injury research area towards the more metropolitan, regional and national levels once the Institute's surveillance initiatives are activated;
6. Investigate at the methodological, theoretical and policy levels the place of the social and health sciences in the promotion of safety and the provision of psychosocial health care;
7. Activate ongoing evaluation of the Institute's community-based safety promotion initiatives through appropriate methodologies; and
8. Promote the institutional and organisational changes required for a range of robust non-medical health services.

As a priority for the ISHS and the CPA is the enhancement of its status as a *WHO Collaborating Centre for Injury and Violence Prevention*, as well as its designation as a *National Research Foundation Unit*. Within this broad context, the ISHS gives particular attention to the prevention of injuries due to violence and unintentional causes.

Since 1990, the Institute has maintained its Centre for Peace Action in the Johannesburg south west suburbs of Eldorado Park, Ennerdale, Lenasia and Chiawelo as a test-bed for the development and evaluation of community-based violence and injury prevention programmes. More recently, in 1997, the Institute began safety promotion programmes in several Helderberg communities of the Strand in the Western Cape. The Centre - drawing on the surveillance and other epidemiological data focuses on testing the development of services for the prevention of injuries due to violence and accidents and the psychosocial care of survivors of violence. Following the principles of best practice, its interventions include youth and women's services, counselling facilities, home and community safety programmes and traffic safety initiatives. With the Johannesburg South-West Metropolitan Council, the Centre has since 1997 been a member of WHO's Global Network of Safe Community Demonstration Programmes. For an overview of the Centre see the Karolinska Institute's Safe Community web site at: <http://www.ki.se/phs/wcc-csp/safecom/main.html>.

The CPA's approach to safety promotion is structured around the following safe community principles of intervention:

- Create a cross-sectoral group responsible for injury prevention;
- Involve all levels of community (e.g. friendship groups, organisations (including health care providers, civic associations and schools) in injury prevention and safety promotion;
- Create an injury database that reflects the extent of the injury problem among all age groups, and in all environments and situations in order to expand CPA activities to cover all ages, environments and situations;
- Work with high-risk groups and subgroups in an effort to enhance safety-related equity and justice;
- Develop capacity through the recruitment of local residents as field interviewers and data capturers;
- Be an ongoing long-term programme;
- Ensure adequate formative, process and outcome evaluation;

- Disseminate experiences both locally and nationally; and
- Contribute to a strong network of “Safe Communities”.

Underlying the Institute’s work, is the slogan *local evidence for local safety action*, a phrase that captures the ISHS’s and CPA’s commitment to improving safety and health through evidence-led action and evaluation at the local level. In addition, all our interventions are predominantly guided by and embedded within community psychology, public health, research psychology and behavioural health theory.

## **PART TWO**

**CENTRE FOR PEACE ACTION  
A UNIVERSITY OF SOUTH AFRICA  
INSTITUTE FOR SOCIAL AND HEALTH  
SCIENCES PROGRAMME  
AND  
A MEMBER OF THE SAFE COMMUNITIES  
NETWORK  
WHO**

## **4 Background. The Centre for Peace Action: Mission and Vision**

Since 1990, the Institute has maintained its Centre for Peace Action in the Johannesburg south west suburbs of Eldorado Park, Ennerdale, Lenasia and Chiawelo as a test-bed for the development and evaluation of community-based violence and injury prevention programmes. More recently, in 1997, the Institute began safety promotion programmes in several Helderberg communities of the Strand in the Western Cape. The Centre - drawing on the surveillance and other epidemiological data focuses on testing the development of services for the prevention of injuries due to violence and accidents and the psychosocial care of survivors of violence. Following the principles of best practice, its interventions include youth and women's services, counselling facilities, home and community safety programmes and traffic safety initiatives. With the Johannesburg South-West Metropolitan Council, the Centre has since 1997 been a member of WHO's Global Network of Safe Community Demonstration Programmes. For an overview of the Centre see the Karolinska Institute's Safe Community web site at: <http://www.ki.se/phs/wcc-csp/safecom/main.html>.

Fundamental to the CPA's approach is the public health vision of injuries due to violence and other causes as a major contributor to death, disability and psychosocial morbidity, and therefore to the global and national burden of disease. Central to this vision is a focus on changing the social, behavioural and environmental factors that cause injuries and violence. Accordingly, the behavioural tendencies of individuals and groups are not seen as the origin or end-point of injurious action, but as the outcome of causal relationships between individuals and other people (e.g. peers, parents), individuals and products (e.g. guns, alcohol, motor vehicles; fossil fuels), and individuals and environments (i.e. physical and social). These relationships are the lines of risk for violence and injury, and through appropriate research and intervention can be manipulated to prevent the problem.

## **5 Introduction: The Safe Community Indicators**

The target for the safe community network and its joint programme are groups of people with common interests, such as residence in the same place (e.g. a municipality), or membership of the same group (e.g. a voluntary organisation). In the case of the Institute for Social and Health Sciences (ISHS or Institute hereafter) and its Centre for Peace Action (hereafter CPA) the community in question is geographically defined by residence in the township of Eldorado Park, which itself is made up of three sub-groups on the basis of neighbourhood type: People living in informal (shanty) settlements; people living in three storey municipal apartment blocks, and people living in four-room houses rented from the municipality. As shown in Appendix 1, each of these neighbourhood types manifests its own, very distinct pattern of injuries and risk factors, requiring that while the programme must think community-wide it must act at neighbourhood level. In the mid-nineties the CPA extended its community safety work into the neighbouring areas of Lenasia including the informal settlement of Thembelihle, Ennerdale and several communities on the east coast of the Western Cape.

According to the indicators developed within the Safe Community network the following requirements must be met for an organisation to be a member of the Safe Community Network:

- The existence of a cross-sectoral group responsible for injury prevention;
- Involvement of the local community network;
- A programme covering all ages, environments and situations;
- The programme must show concern for high risk groups and high risk environments and aim particularly at ensuring justice for vulnerable groups;
- Those responsible must be able to document the frequency and causes of injuries;
- The programme must be a long-term programme rather than a short-term project.

The community must also undertake to:

- Utilize appropriate indicators to evaluate processes and the effects of change;
- Analyse the community's organizations and their possibility of participation in the programme;
- Involve the health care organisation in both registration of injuries and the prevention programme;
- Be prepared to involve all levels of the community in solving the injury problem;
- Disseminate experiences both nationally and locally;
- Be prepared to contribute to a strong network of safe communities.

## **6 Eldorado Park and the Centre for Peace Action: A Safe Community?**

### **Eldorado Park: A Demographic and Economic Overview**

The information that follows reflects the best currently available demographic and historical information about Eldorado Park and the context of greater Johannesburg, and in respect of the relationship between the CPA and the community is derived from the experience of nearly ten years that the CPA has been active in the area, as well as household surveys conducted by the CPA.

Eldorado Park is a residential area of around 85 000 inhabitants, most of whom are low to middle-income employees in industry, the commercial and informal sectors, or else out of work. People live in three main types of neighbourhood, as defined by the predominant housing in each neighbourhood.

**1. Informal settlements.** Steadily increasing in size since the country's democratization enabled migration to the towns and the cities, are the informal settlements, shanty towns made up of huts built with wood, zinc, plastic and other cast-off materials. Residents in these settlements are almost exclusively black African, and they account for around 40 percent of all homes in the area.

**2. Council housing.** Rented four-room council housing is the next most common residence type. These homes also account for about 40 percent of all residence types, and people who live in these neighbourhoods tend to be mainly “coloured”, a term used by the apartheid state to refer to people with mixed origins.

**3. Council apartments.** Rented apartments in three to four-storey blocks form the last neighbourhood type, and account for around 20 percent of all residences. As with the houses, these are occupied mainly by “coloured” people, for whom Eldorado Park was an officially designated township until the 1991 scrapping of the apartheid “Group Areas” Act.

In 2000 there are still very few formal businesses within Eldorado Park, and a paucity of public recreational facilities (there are no cinemas, no hotels, no formal sports grounds and only few commercially run recreational areas). This reflects the fact that, for the approximately 50 percent of people who are formally employed, Eldorado Park serves as a “dormitory township” for workers employed beyond its boundaries. The remaining half of the residents are either occupied in the informal sector (e.g. car repairs, running of unlicensed bars, small-scale retail of food and drink), or simply “do nothing”.

As shown in Table 3 of Appendix 1, informal settlements have between three and four persons per dwelling (often consisting of only two rooms and in many instances only one room); and the houses and apartments between five and six persons per dwelling (of two to three rooms). These density figures are closely similar to those for the various suburbs that constitute neighbouring Soweto. In comparison, historically white, middle income suburbs in Johannesburg return a density of around four persons per house (of four to five rooms), and two per “town house” (of three to four rooms). In 1991, the annual per capita income for Eldorado Park residents was estimated as R11 493. This was slightly more than the per capita income reported for Soweto (R8 683), but some four times less than that calculated for residents of an average middle to upper income suburb (R45 000).

### **The CPA: Origins and Activities**

The CPA was initiated in 1990 as an outcome of the first hospital-based epidemiological study of injuries in Johannesburg. According to this 1989-1990 survey, “coloured” residents of Eldorado Park manifested the highest injury incidence of all groups, and the highest rates of non-fatal violent injuries. Strong age and gender-related trends emerged for both incidence and causal profile, the highest risk occurring among males aged 15 to 30, and among women in the age range 15 - 35. By age and cause, unintentional injuries dominated up to the age of five, while from six years until the age of 45 violence accounted for the largest proportion of injuries. For violent incidents, scrutiny of the victim-perpetrator relationship suggested that men were equally likely to be attacked by strangers as by acquaintances, incidents most often involving sharp instruments and occurring “on the street”. In contrast, nearly 40 percent of women were attacked by spouses and lovers, and a further 32 percent by acquaintances. These attacks on women occurred most frequently in the home, some 50 percent involving knives, 20 percent fists and feet, and around 15 percent blunt instruments.

During 1989-1990, these and other such data were disseminated through meetings with community groups, local government and health sector agencies, the corporate sector and international donor agencies, with the aim of securing multi-sectoral support and funding to launch a programme directed at violence prevention through community development. These efforts were successful, and the Centre commenced its first full year of operation in 1990 with a staff composed of professionals and community residents. Over the last ten years, its prevention programmes have become increasingly consolidated and focused in terms of

objectives, target groups and record keeping, and the Centre has achieved a stable and well-respected presence in the immediate communities it serves. Plans are now in place to train a group of volunteers, mainly women to assume administrative and organizational responsibility for the CPA's Eldorado Park Offices and injury prevention programmes in Thembelihle and Nomzamo, in the Western Cape.

Despite its success as a service delivery organisation, an earlier major limitation of the Centre was its inability to evaluate the effectiveness of its interventions at the aggregate level of the population. It was in an attempt to overcome this limitation that in 1995 the CPA was successful in obtaining funding from the Medical Research Council to perform a household survey of injury patterns and risk factors in each of the main neighbourhood types that make up the area. This programme soon became known as the "three neighbourhoods safety promotion programme" and a synopsis of the results from the baseline survey conducted in 1996 appear as Appendix 1. These data have been used to establish problem-specific interventions (e.g. pedestrian transport safety, burns in the home, domestic violence) that involve the local community and the town council, and serve as comparative data for repeat surveys once the interventions have been fully implemented.

While initiated by social scientists in the former Health Psychology Unit<sup>1</sup>, the CPA was from its inception designed as a community-based programme that would operate as a partnership between professionals and community residents, who are members of both the CPA staff and the Centre's Governing Board.

### **The CPA's Opinion about WHO Recognition as a Safe Community**

Since late 1995 the ISHS has been a WHO Collaborating Centre for Injury and Violence Prevention, and in this role has been able to draw strongly on the experience and example of the CPA as an applied injury prevention initiative that is both community-based and information-driven. In addition to the obvious value of being able to disseminate the CPA's lessons through the Institute's already established global and regional network, WHO recognition of the CPA as a "safe community" remains important for a number of reasons.

1. The CPA is a unique endeavour (not only in South Africa but in Africa more generally), bringing together professionals and community residents around the issue of injury prevention through a combination of community development and public health principles. WHO recognition consolidates this alliance by identifying the programme with similar initiatives elsewhere in the world and confirming to its many stakeholders at a local and national level that what they are doing is in line with broader international trends.
2. Designation as a "safe community" serves to enhance the CPA's visibility and strengthen its credibility as an educational and change agent in the field of health policy formulation and injury prevention capacity development. Professional staff of the Institute are influential players in the development of South African health policy for injury and violence prevention, and WHO accreditation of the CPA has served to enhance this policy-making role.
3. WHO recognition affords an increased opportunity for collaboration and exchange with

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<sup>1</sup>In 1997 the Health Psychology Unit was amalgamated with another University enterprise, the Institute for Behavioural Sciences (IBS), to form the current Institute for Social and Health Sciences (ISHS).

colleagues from other parts of the world, as was demonstrated when the CPA hosted the *Sixth International Conference on Safe Communities* in October 1997.

4. WHO accreditation of the programme has helped the Centre to lobby local government to deliver on its already promised commitment to putting in place environmental modifications to make the Eldorado Park community safer. By signing the safe communities agreement, these individuals make a very public statement of their organisations' commitment to investing in safety, and thereby undoubtedly help to increase their sense of moral obligation to act on their promises.
5. Being a member of the "safe communities" network strengthens the CPA's hand in its ongoing endeavour to secure stable and long-term funding, preferably from a local as opposed to the present shrinking international donor base.

## **7 The Safe Community Indicators related to the CPA**

Since beginning as a dedicated violence prevention agency in 1990, the CPA has expanded its activities to cover most of the main areas of community safety concern as revealed by the 1996 baseline survey of its "three neighbourhoods" safety promotion programme.

### **7.1 The Existence of a Cross-sectoral Group Responsible for Injury Prevention**

Cross-sectional involvement in the promotion of safety is maintained through links with the following agencies and organisations.

#### **State and Local Government**

The National Department of Health, Directorates of Mental Health and Substance Abuse, and Health Information

Gauteng Province Health Department

Gauteng Ministry for Safety and Security

Johannesburg Southern Metropolitan Council

The Eldorado Park and Kliptown police stations

#### **Community Groups**

Eldorado Park L.P.C.

Pimville Neighbourhood Watch

ANC Eldorado Park

Merry Makers

The Peoples' Voice

Advice Centre

Eldos Advice Centre

Eldorado Park Cultural and Recreational Group

Community Resource Forum

Pimville Residents Association

Brotherhood Organisation

Eldorado Park Community Policing Forum

Eldorado Park Rate Payers Association

#### **Local Schools**

Silver Oaks High  
Heerengracht Primary  
CL Magardi Primary  
Firethorn Primary

Kliptown High  
EW Hobbs Primary  
Willow Crescent High

### **Universities and Research Organisations**

University of the Witwatersrand  
University of South Africa  
Medical Research Council  
Human Sciences Research Council  
Technikon SA

As of November 2000, the Institute and its CPA has a staff of 22. Three of the staff are tenured academics at the University of South Africa, where they belong to the Institute for Social and Health Sciences. The remaining staff are all funded from donor money received by the CPA as grants to perform its services and research. Many of the staff are residents of the community in question, and some of the staff are intern research and counselling psychologists, the CPA being an accredited training centre for psychologists in these categories. While many of the staff have a background in the psychological sciences, some are social workers and others come from contexts of small business development and conflict resolution work.

## Institute and CPA Staff, November 2000

NAME & SURNAME	DESIGNATION
Bulbulia A.	Community Intervention Co-ordinator, Cape Town
Burrows S.	Junior Researcher
Butchart R.A	Associate Professor
Dreyer M.	Human Resources Manager
Gertze S.	Housekeeper/Caterer Lenasia Offices
Jaggan V.	(Long Leave)
Lekoba R.	Field Work Co-ordinator
Lourie L.	Programme Administrator
Mathebula B.P.	Office Clerk
Moabi J.R.	Maintenance and Office Manager
Mohamed F.	Counselling Psychology Intern
Nell V.	Professor
Ntaka G.N.	Women's Services Field Co-ordinator
Peteke V.	Receptionist/Typist
Seedat M.A.	Director/Associate Professor
Senyane M.J.	Housekeeper: Eldorado Park Offices
Stevens G	Youth Programme Co-ordinator Researcher
Swart L.	Junior Researcher
Swart T.	Community Counselling Psychology Intern
van Niekerk A	Safety Programme Research Manager
van der Walt C.	Community Counselling Psychology Intern
Wyngaard G.	Youth Work Co-ordinator

The cross-section of groups and individuals that make up the CPA's staff is also reflected in its Governing Board. To ensure adequate community representation and the involvement of outside interest groups, the Governing Board is nominated for a two year period. Each year, they attend a day-long workshop where strategies for the forthcoming year are designed in consultation with CPA staff, and the board members are appraised in what is expected of them.

## **Governing Board, November 2000**

Prof L. Molamu  
Vice-Dean: Social Sciences  
Chairperson

Dr Ahmed Vally  
Psychiatric Registrar (Tara Hospital)  
Vice-Chairperson

Mrs Anne Duiker  
South African Revenue Services

Prof FJA Snyders  
Head: Psychology Department

Prof L. King  
Head: Advanced Nursing Sciences Department

Prof M. de Jongh  
Head: Anthropology and Archaeology

Mr Johan Muller  
Head: Finance Department

Prof M. Seedat  
Ex-Officio ISHS Representative

### **Patrons**

Dr Ram Saloojee  
Medical Practitioner and  
National Assembly Parliamentarian

Mrs Nandi Mayathula-Khoza  
Mayor, South Johannesburg

The CPA has two patrons: Dr Ram Saloojee, a medical practitioner and ANC Member of Parliament, and Mrs Nandi Mayathula-Khoza, the current mayor of Johannesburg South.

## 7.2 Involvement of the Local Community Network

Following an external programmatic evaluation in 1998-9, the CPA has adopted a more focused approach to its work that is acutely keyed into the Safecom principles. Particular attention is given to linking data to action. The CPA now implements its objectives through seven-interrelated core activities. Each activity operates as a link by which the wider community network of friendship groups, organisations, civic associations, schools and so on, can be recruited into injury prevention and safety promotion.

**1. Womens Led Safety Promotion and Leadership Development.** Due to both cultural and economic factors, women are doubly disempowered and therefore at risk for both intentional and unintentional injuries, their exposure to the latter being greater than for violent injuries owing to their role in the home where they must cook, clean and care for children. The women's led safety promotion and leadership development project seeks to address this disempowerment in three ways. First, counselling is offered to women who are at risk, or have already become victims of violence, in an effort to prevent revictimization and create a greater scope of choice. Second, leadership development is aimed at insulating women against all forms of injury by increasing their capacity to take active command over their own lives and enable them to better 'bargain' with men in the quest for equity in respect of power and safety. The leadership development also helps prepare women to assume responsibility for programmatic intervention. Third, volunteer groups, comprising mainly of women are trained to serve as safety promotion agents in their respective communities. Once trained these volunteer groups serve as first-responders, provide post-hospital care, conduct home visits to encourage safety and injury prevention at household level. The volunteer groups are also responsible for information dissemination, safety campaigns and linking injury data to safety action which includes advocacy and community mobilisation.

**2. Family Counselling and Development.** Internationally, it has been shown that the quality of parent-child relationships and the general level of family support available to an individual are important predictors of exposure to injury. Family counselling and development therefore target the fabric of the family, with a particular focus on young mothers; parent effective training, and the provision of psychometric testing and neuropsychological assessment for individual children and youth who are identified by parents and teachers as under-performers in the home and at school.

**3. Youth and Schools-based Services.** From mid-adolescence onward, young people are ubiquitously over-represented among victims of violence and injury. Youth and schools based services thus target this high risk group with training in life skills and leadership as well as awareness raising about injury prevention in general through a "safe schools" programme. The safe schools initiative, which is at the heart of the youth safety project, currently involves 14 schools (7 in Gauteng and 7 in Western Cape). The safe schools initiative is designed to restore schools as safety resources through which the catchment communities may promote injury prevention.

**4. Community Outreach Services.** Through community outreach, the CPA aims at disseminating the safe community approach both within Eldorado Park and nationally. This is achieved through workshops, media campaigns, and the preparation of teaching materials,

and distribution of several newsletters. As part of its outreach work the CPA links organically emerging support groups to training and financial resources. These community groups are significant sites of resilience and safety promotion.

**5. Peoples' History Project.** The Peoples' History Programme recognises that support systems, community connectedness, and a shared identity are integral to safety promotion. It therefore aims to strengthen the social fabric by encouraging residents to reclaim their past by way of a peoples' history newsletter that encourages debate around issues such as the tradition of gangsterism, the history and meaning of alcohol and drug abuse, and youth attitudes to sexuality and violence. This project ear-marked for closure, will have by March 2001, produced several workbooks for use in primary and secondary schools.

**6. Small Business and Safety.** Unemployment and poverty are among the most clearly defined risk factors for injury due to all causes. The small business and safety programme thus aims to enhance safety in two ways. First, by empowering jobless individuals through training in how to run small businesses and facilitating their obtaining of start-up finance from appropriate agencies. Second, by way of documenting the types and causes of injuries sustained by individuals actively employed in the informal sector, which because it does not fall under the umbrella of traditional occupational safety is a particularly vulnerable subgroup for work-related injuries. The CPA networks with various relevant agencies to provide the training in small business development and management.

**7. The Three Neighbourhoods Safety Promotion Programme.** As shown in Appendix 1, the Three Neighbourhoods Programme is both a vehicle by which to evaluate the CPA's ongoing interventions, and an intervention in its own right. As an intervention, the survey data generated by this programme are used primarily to lobby local government for the implementation of environmental modifications (e.g. street lights; traffic calming measures; electrification; formal housing) that cannot be set in place by residents themselves, and which will cover all main injury causes. Presently the CPA facilitates evidence-led safety promotion projects in several informal settlements including Thembelihle in south Johannesburg and Nomzamo in the Western Cape.

**8. Information Management and Documentation.** The information management and documentation programme cross-cuts all other CPA interventions and aims at ensuring the effective recording and evaluation of services delivered.

### **7.3 A Programme Covering all Ages, Environments and Situations**

With the 1995-1996 inclusion of the "three neighbourhoods safety promotion project"; and the Western Cape (1997) and Thembelihle (1998) risk and resiliency projects into its activities, the CPA created a new injury and injury risk database that reflects the extent of the injury problem among all ages, environments and situations. In effect, the baseline surveys constitute a natural experiment in injury prevention, which demonstrate how both violent and unintentional injuries are elevated in informal settlements relative to formal housing areas. In turn, this knowledge has been applied to complement the CPA's predominantly educational and training interventions with a programme aimed at environmental

modification. This is shown by the following executive summary of safety promotion recommendations from a report to local government.

Between May and October 1996, 1 072 homes divided between six neighbourhoods in Eldorado Park were surveyed to establish the incidence and causes of injuries over the past year. The neighbourhoods were two informal settlements (Slovo Park and Mandela Square); two council housing areas (Extension 2 and Kersiedorp) and two council apartment blocks (Bauhinia and Heathfield). 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 of between 3 000 and 8 000 per year in the formal housing areas. For *injuries due to traffic*, a variety of environmental modifications to high risk roads, and the provision of safe crossing points are the main interventions recommended. For *fall injuries*, it is recommended that safety audits of apartment blocks, public spaces and school play areas be conducted to identify and then eliminate risky features such as stair treads, stair and balcony railings, playground equipment, and playground surfaces. *Burn injuries* were mainly a problem in the informal settlements. While electrification and housing improvement is recommended to prevent burns, it also recognized that interim solutions in the shape of improved devices for cooking, heating and lighting 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 suggests that violence can be reduced through community stabilisation and environmental upgrading. Possible interim prevention strategies are then discussed, including the installation of street lighting, 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. The report concludes by observing that because 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, and therefore that the prevention strategies for these two types of cause are not mutually exclusive. A similar report based on the Thembelihle study was presented to the local council and mayor of South Johannesburg in October 2000. Volunteer safety promotion workers from Thembelihle presented the report at the October meeting which was attended by local councillors and other key decision makers. This five part report appears in Appendix 2.

## **7.4 The Programme must Show Concern for High Risk Groups and High Risk Environments and Aim Particularly at Ensuring Justice for Vulnerable Groups**

Rooted in a community that was historically marginalised and disenfranchised by the apartheid state, the CPA epitomises a programme that works with a high risk community and aims to enhance safety-related equity and justice. Within this broad framework, attention is particularly focussed upon the sub-groups most vulnerable to injury, namely residents of informal settlements, young mothers and youth, the unemployed, victims of violence, and child labourers.

## **7.5 Those Responsible must be able to Document the Frequency and Causes of Injuries**

As a project of the UNISA Institute, the CPA is closely integrated with the Institute's quantitative and qualitative research programmes into the epidemiology and determinants of injury. In all of these programmes, emphasis is placed upon capacity development through the recruitment and training of local residents as field interviewers and data capturers. A number of local and international publications have been produced to date, and detailed analysis of the information from the "three neighbourhoods" and two other "risk and resiliency" projects have already been widely distributed through popular and scientific mediums.

## **7.6 The Programme must be a Long-term Programme rather than a Short-term Project**

While its dependence on mainly international donor agencies as a source of funding means that the CPA is vulnerable to changes in funding priority, it has successfully maintained itself since 1990, and is now in its tenth year of existence. Efforts to have the programme permanently funded by local authorities are ongoing, and over the last three years have achieved some successes. Using donor money, the Centre has built its own headquarters on council land leased at a nominal fee for a ten year period, and the council provides office space for its womens programmes and its youth centre at a similarly nominal fee. The University of South Africa strongly supports the initiative, which forms a highly visible and therefore valuable component of its community service mission. As a project of the Institute, the involvement of the several tenured professionals is also ensured.

## **7.7 Utilize Appropriate Indicators to Evaluate Processes and the Effects of Change**

Through the CPA's information management and documentation programme, three levels of evaluation are in place or are constantly modified to evaluate its activities:

**1. Formative evaluation** is provided by quantitative and qualitative surveys of injury and injury risk in neighbourhoods and in special populations (e.g. the elderly; schools; informal businesses).

**2. Process evaluation** is built into each of the component interventions by way of questionnaires and focus group discussions with target groups. Process evaluation for the programme as a whole is achieved through monitoring and documenting its impact on policy and practice at the level of related community organisations, local government, and national programmes.

**3. Outcome evaluation** is built into the CPA through its “three neighbourhoods” programme. It is anticipated that once environmental interventions have been implemented, all the baseline surveys will be repeated in the various neighbourhoods initially surveyed. At present, we are in the throes of repeating a risk survey in Thembelihle.

## **7.8 Analyse the Community’s Organizations and their Possibility of Participation in the Programme**

The CPA’s community outreach programme constantly monitors the nature and role of community organizations in the area, and works on an ongoing basis to enhance their participation in the programme. As part of all its surveys, respondents were asked to name agencies they were aware of in the area, and indicate what these agencies did. The responses indicated that very few local agencies were active, and that of local government service groups those involved in water and sanitation were the most prominent. Through its own network of community contacts, the CPA has identified student leadership groups, women agencies, church groups and community policing groups as among the best developed of existing agencies, all of which are cooperatively involved in the safety promotion venture. Leadership in the informal settlements is particularly weak, owing to a combination of high transience among residents (who live in these areas for an average of two to three years), and a rapid turnover of community leadership. However, after five years of constant presence in Thembelihle for instance, the CPA has now identified a women’s led volunteer group that is supported through training to promote safety in the community. Similar developments have occurred in Eldorado Park and the Western Cape neighbourhoods.

## **7.9 Involve the Health Care Organisation in both Registration of Injuries and the Prevention Programme**

Residents of living in the Centre’s catchment areas present to some six separate state health care facilities and an unknown number of private doctors. While it is desirable that these agencies should be involved in the surveillance of injuries, this is a long term goal that is currently the focus of a national pilot initiative to create an injury surveillance system in nine pilot areas of the country. The Institute is part of this initiative, and so routinely collects data from participating mortuaries, trauma units and hospitals.

Health care organisations are involved in the prevention of injuries through the community health division of local government, and by way of the CPA’s link to the local Disaster Management and Emergency Services, a voluntary group of paramedics who treat a reasonable proportion of injury cases occurring in the community. More substantive involve-

ment of the health sector in prevention is an ongoing aim of the CPA and the Institute, as the organisation works to promote injury prevention as a local, regional and national health priority.

## **7.10 Be Prepared to Involve All Levels of the Community in Solving the Injury Problem**

The primary aim of the CPA is to achieve injury prevention through the use of information and the recruitment of all levels of the community in solving the problem. Its interventions are therefore aimed at viewing every community resident as both a consumer of injury prevention knowledge and a resource for prevention. To this end, three levels of intervention are conceptualised.

**1. Level one interventions** involve using data to stimulate injury prevention activities that residents can themselves perform without additional training. This is done by convening public meetings in various neighbourhoods, at which quantitative and qualitative injury information specific to each neighbourhood are set out as poster displays. These displays are broken down into sub-sections detailing each of the major causes (e.g. transport, violence, burns). Following a general introduction to the programme, participants are invited to discuss the displays with programme staff and the field interviewers. Among the interventions at this level which have been suggested are clean-up campaigns to remove dangerous waste objects (e.g. glass, zinc sheets, wire) from the outside environment, and a home safety day, when residents would inspect their homes for dangerous objects and substances (e.g. poisons, blades, matches/lighters, flammables), and dispose of those no longer needed, while ensuring the safe storage of items to be retained.

**2. Level two interventions** use injury information to guide the provision of appropriate training to local residents in an effort to empower their own injury prevention capacity. For instance, residents in the informal areas viewed the provision of better day-care for young children and infants as an important way of separating these children from hazards such as the poisons they would encounter if left alone in their homes, or motor vehicles on the peripheral roads. Accordingly, a group of women were trained in how to operate crèches and other kinds of income-generating projects. These projects serve to strengthen community support systems for vulnerable individuals and groups.

**3. Level three interventions** focus upon risk factors that cannot be altered by residents acting on their own, such as speeding motor vehicles on a national highway, the lack of electrification, the absence of police services, and informal housing. These interventions use injury information to draw local government into the implementation of engineering and enforcement interventions aimed at making the environment safer.

## **7.11 Disseminate Experiences both Nationally and Locally**

The CPA is a vigorous champion of safety promotion through the safe communities approach, and every year presents dozens of workshops, conference papers and seminars to groups both within South Africa and internationally. In October 1997 it will host the *Sixth*

*International Conference on Safe Communities* and its travelling seminar. In addition to these dissemination modalities, the CPA maintains a good rate of publication in both popular and scientific journals. The CPA has frequently hosted international visitors interested in violence prevention and safety promotion, and its staff are encouraged and enabled to attend relevant international meetings on an annual basis.

In 1998 it co-hosted the First African Regional Safecom Conference in Zimbabwe and is currently preparing for the Second Regional conference scheduled for April 2001. The CPA also produces a number of newsletters for distribution in the country and on the continent.

## **7.12 Be Prepared to Contribute to a Strong Network of Safe Communities**

The CPA is committed to establishing safety promotion as a regional priority in sub-Saharan Africa, and currently acts as a founder and participant member in the “Southern African Injury Prevention Network”, which publishes a quarterly newsletter in collaboration with the Medical Research Council’s National Trauma Research Programme. As a prominent initiator of injury prevention in Africa, the CPA views its main contribution as being to the African continent, while not neglecting the fact that its evolution and existence in the very remarkable setting of South Africa means it may have much to share with colleagues around the world, especially those located in low to middle-income regions.

# **APPENDIX 1**

## **INJURY AND VIOLENCE IN ELDORADO PARK: A NEIGHBOURHOOD EPIDEMIOLOGICAL PROFILE AND RECOMMENDATIONS FOR SAFETY PROMOTION**

**Report Prepared by the Three Neighbourhoods Safety Promotion Team**

One among other external causes that produce physical injury and psychosocial damage, levels of violence in South Africa correspond closely with the extent of injuries due to unintentional causes - such as household burns, falls, and transport-related injuries - which occur more often in settings where there is more violence. Underlying this covariance are those risk factors - such as unemployment, family dysfunction, environmental degradation, alcohol and substance abuse - that are shared by violent and unintentional injuries.

Although not a surprising observation, this recognition has rarely been translated (at least in South Africa) into efforts at initiating and implementing information-based violence and injury prevention programmes targeted to local level variations in injury cause. It is therefore the aim of this report to present some preliminary results from a larger, ongoing safety promotion programme in a Johannesburg township, in the hope that the data will encourage the implementation of effective safety promotion interventions. The survey reported on here was conducted between May and October 1996.

### **METHODOLOGY**

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 information.

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 settlements, which in combination accounted for around 85 percent of all residents. To 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 neighbourhood a random sample of households was drawn. The most senior female resident within each household was used as a proxy respondent for all other persons sharing the dwelling. Local residents 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 ratter about the injury incidents they listed, to yield a highly satisfactory reliability. Table 1 shows the final sample size, indicating the number of households and the total number of respondents by proxy per area.

Using version ten of the International Classification of Diseases<sup>1</sup>, all injury descriptions were allocated codes for external cause and body area injured. The data were captured using MicroSoft Access, and analysed using EpiInfo6 and SPSS.

### **A NEIGHBOURHOOD INJURY PROFILE**

Analysis is as yet far from complete, and the results reported here provide only an overview of the injury profile generated for each neighbourhood, along with some information about possible risk and resilience factors.

**Table 1: Injury and Demographic Information by Neighbourhood**

	<i>Informal A</i>	<i>Informal B</i>	<i>Houses A</i>	<i>Houses B</i>	<i>Flats A</i>	<i>Flats B</i>	<i>TOTAL</i>
Total Dwellings	174	317	124	307	53	100	1075
Total Residents	669	998	701	1529	289	543	4729
Number Injuries	100	150	47	60	24	13	394
Number Mortalities	7	7	0	7	2	0	23

*Injuries include morbidity and mortality.*

*Mortality = non-natural causes during previous year.*

**Table 2: Injury Incidence by Neighbourhood**

<i>Incidence</i>	<i>Informal A</i>	<i>Informal B</i>	<i>Houses A</i>	<i>Houses B</i>	<i>Flats A</i>	<i>Flats B</i>	<i>TOTAL</i>
Injury Incidence 95% CI	14947 ±1379	15030 ±1131	6704 ±945	3924 ±497	8304 ±1623	2394 ±656	8331 ±402
Morbidity 95% CI	13901 ±1338	14329 ±1109	6705 ±945	3466 ±468	7612 ±1560	2394 ±656	7845 ±391
Incidence Mortality 95% CI	1046 ±393	701 ±264		457 ±173	692 ±488		486 ±101

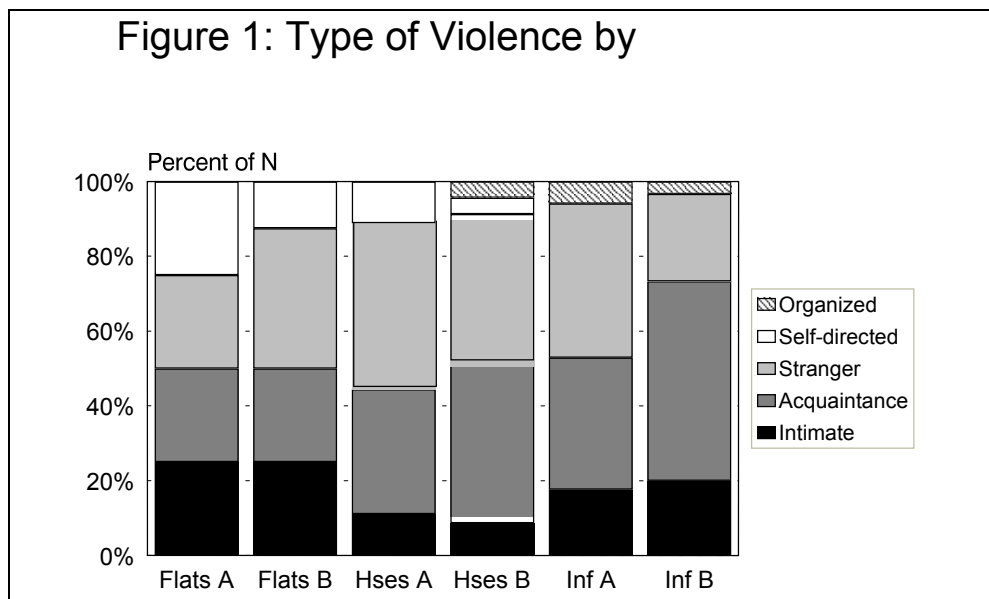
### **Magnitude of the Injury Problem**

As shown in Table 1, a total of 394 injuries were reported as having occurred over the past year in the 1 075 households sampled. Of these injuries, 23 resulted in death. Converted to a rate per 100 000 residents per annum, the injury rate for the full sample was 8 331 per 100 000. Overall injury incidence rates varied markedly between the areas (see Table 2). Both informal settlements returned incidence rates of around 15 000/100 000, twice that reported for the Ext. 2 houses and Bauhinia flats. The safest areas were Kersiedorp (3 924/100 000) and Heathfield flats (2 394/100 000). Mortality rates were also elevated in the informal settlements, although the very small sample size on which these rates were calculated means that they have a large confidence interval.

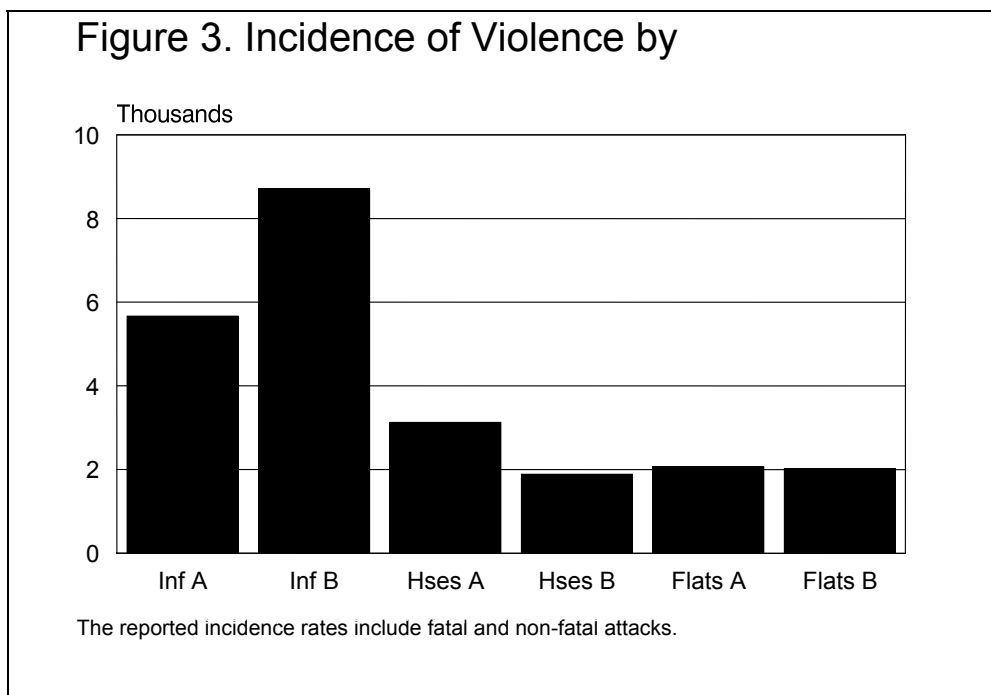
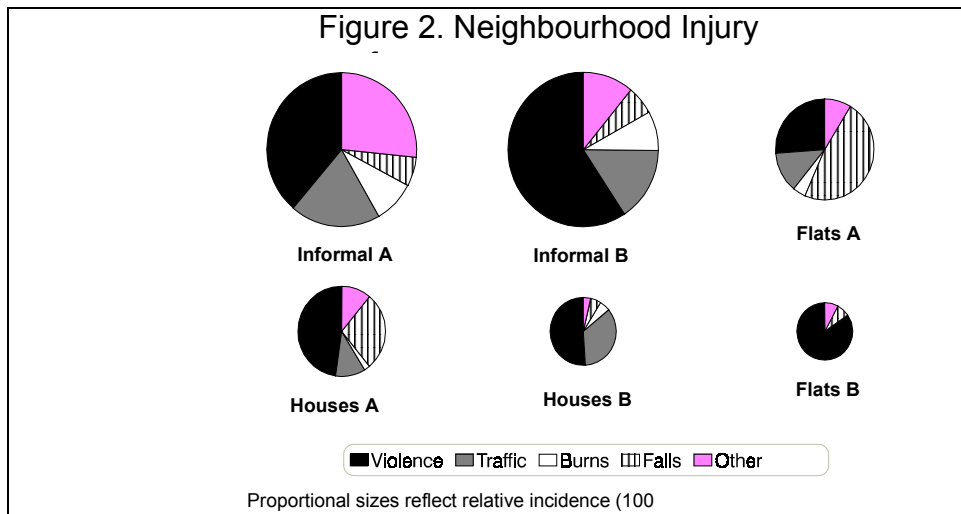
**Injuries due to Violence.** The single largest injury cause for the full sample was violence, which accounted for 48 percent of all injuries. Following WHO<sup>2</sup>, it is useful in conceptualising prevention strategies to divide sub-types of violence into categories on the basis of the victim perpetrator relationship and the degree of organised intent. This yields five main types of violence: Intimate violence (e.g. child and wife abuse); Acquaintance violence (e.g. between drinking partners); Stranger violence (e.g. violence in the course of robbery, rape by an unknown attacker); Self-directed violence (including suicide and self-mutilation);

Organised violence (e.g. war and factional conflicts).

As shown in Figure 1, the main forms of violence in all areas involved intimate and acquaintance violence, which together accounted for between 50 and 60 percent of all instances, and occurred most often in homes and other private settings. Stranger violence occurred for the most part on the street within the immediate vicinity of the victims= homes, although women were more likely than men to be attacked by strangers in their homes. These data suggest that traditional approaches which emphasise visible policing in public spaces may have some impact on the approximately one third of cases that occur in such settings, but that very different prevention measures will be needed to address the problem of intimate

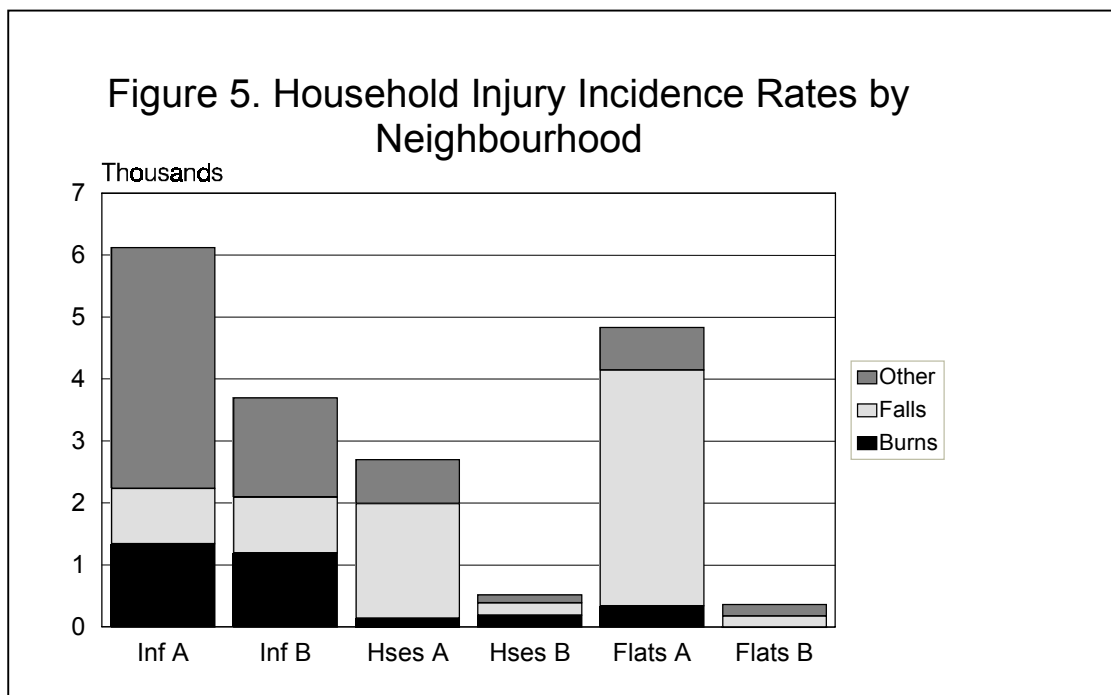
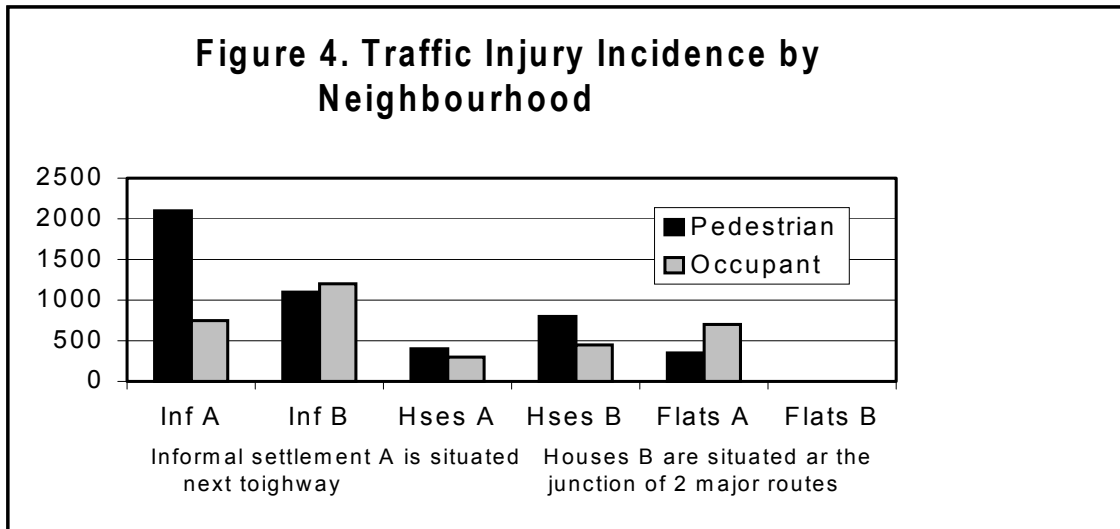


and acquaintance violence. However, at least in the informal settlements surveyed in this programme, such observations are purely academic, since they currently are not served by police patrols at all, and residents that make use of the police, go the local police station themselves. As shown in Figure 2, the contribution of violence varied between areas, accounting for highs of 59 and 85 percent of all injuries in Mandela Square and Heathfield, against lows of 39 and 26 percent in Slovo Park and Bauhinia. However, these differences in the proportion of violent injuries say nothing about actual levels of violence, since they are relative to the contribution made by other unintentional injury causes, such as transport and burns. Thus, although violence in Slovo accounted for only 39 percent of its injuries, the violent injury rate here was 5 680/100 000 (see Figure 3), which although less than in Mandela Square was twice that recorded in any of the other neighbourhoods. The data showed that 43 percent of all violent injuries were alcohol-related, and that the percentage use of alcohol use in the mornings was substantially elevated in the informal settlements where the incidence rate for violent injuries was highest (see Table 3).



**Injuries due to Traffic Injuries.** Figure 4 shows the incidence rates for traffic injuries, which, as for violence, were highest in the informal settlements, and especially so in Slovo Park. This neighbourhood is built directly alongside a high-speed freeway with no traffic calming measures, no pedestrian barriers and no facilities for safe crossing. Since all schools, shops, and other amenities are situated in formal housing areas directly across the highway,

residents of Slovo Park have little choice but to cross it and risk fatal injury or at best severe disability. Similar environmental risks applied in Kersiedorp, which is also adjacent to a main arterial road characterised by a dangerous mix of pedestrians and speeding vehicles.



**Injuries in the Home** Injuries in the Home. Figure 5 shows the incidence of unintentional household injuries. Once again, these were highest in the informal settlements, where dependence on fossil fuels for heating and cooking (see Table 3) correlated with a substantially higher incidence of burns. Similarly, the proportion of injuries due to other causes (e.g. snake and spider bites, being injured by hand-held agricultural implements) was also elevated in the informal settlements, where residents are exposed to a far greater variety

and complexity of risk factors than those in formal housing areas. Of the formal housing areas, Bauhinia Flats was the only anomaly, returning an incidence rate for injuries due to falls of just over 3 806/100 000.

**Table 3: Risk and Resilience Factors**

	Informal A	Informal B	Houses A	Houses B	Flats A	Flats B
Avg persons per dwelling	3,85	3,15	5,65	4,98	5,45	5,43
Avg nr of rooms	1,45	1,16	2,74	1,91	2,67	2,87
Transience (stay here, in years)	2,9	2,6	16,1	12,3	14,7	10,4
Home fuel type	Paraffin	Paraffin	Electricity	Electricity	Electricity	Electricity
% Not employed*	55,4	47,8	57,2	58,1	57,3	55,8
% Use alcohol *	43,7	38,8	31,5	31,7	34,3	28,9
% use alcohol mornings *	12,4	14,3	1,9	9,2	2,3	1,3

\* Indicates adults 21-65 years

**Risk and Resilience Factors.** Of the risk and resilience factors listed in Table 3, only average persons per dwelling, duration of stay at present address, and alcohol use in the mornings distinguished between the areas (this is a highly selective table, and does not report on any of the as yet unanalysed risk factors investigated). The informal settlements had fewer persons per dwelling than in the formal areas, but since these informal dwellings are themselves far more densely spaced than the formal households, this cannot be read as an index of crowding, which by another measure would probably be highest in the informal areas. Residents of the formal areas had lived in their dwellings for between four and seven times as many years as residents of the informal areas, suggesting that transience may be an important risk factor for injury, although it is not yet possible to comment on its correlation with environmental and other risk factors. As already noted, home fuel type showed a strong association with the incidence of burns, while the percentage of respondents using alcohol in the mornings was highest in the informal settlements with the highest injury rates.

### IMPLEMENTATION

Scrutiny of the results= intervention implications suggested that different types of injury demanded different levels of intervention, and that prevention measures could be conceptualised at three different levels(1). Actions that can be undertaken by residents themselves on the basis of information only (e.g. clean up campaigns); (2) Actions that could be taken by residents once they had received training in special skills (e.g. first aid; child care; basic victim support and advice), and (3) Interventions that could only be implemented by local authorities (e.g. traffic calming measures; lighting and sanitation; housing).

To address each of these levels, implementation of the survey data is an ongoing activity

aimed at linking problems with prevention resources, and involves feeding the information back at three levels. First, to community residents themselves, by way of weekend safety workshops and through simple injury fact books. Second, to other interest groups who may have the resources to provide appropriate training to residents of the different communities, or may be able to provide requisite services, such as mobile telephones or basic first aid points. Third, to local authorities responsible for management of the environment and stabilisation of communities, which, given that environmental changes are perhaps the most powerful modes of preventing injuries due to violence and unintentional causes, have a fundamental role to play. This process of implementation is underway, and the effects of the intervention should soon start to become visible. Of especial salience in respect of process and outcome will be to monitor the responsiveness of local authorities to the information-based arguments for environmental interventions.

### **RECOMMENDATIONS FOR IMPROVING SAFETY**

The information reviewed above suggests that, especially in regard to non-violent injury causes, there are a number of concrete environmental interventions which will have an immediate and sustained injury reduction effect. In turn, this will translate into reduced expenditure on emergency medical care, reduced time off work and therefore fewer injury-related lost earnings, and reduced disability levels. Ultimately, all these costs are borne by the tax payer, and a one-off investment in environmental changes that can reduce injuries will be recouped in the medium term, and in the long term convert into a saving of finances that could then be diverted to more constructive development activities.

The recommendations are specific to the different injury causes and to the different areas surveyed. However, certain interventions can with confidence be generalized to areas beyond the neighbourhoods surveyed, and it is therefore suggested that while interventions should commence in the six survey areas, they should as far as possible be spread to all other areas. This will ensure that the effectiveness of the interventions can be assessed through a repeat survey of the six measurement areas a year or two after the interventions have been implemented, while not limiting the possible benefits of intervention to these areas.

### **TRANSPORT RELATED INJURIES**

Motor vehicles were the predominant cause of transport-related injuries in all areas, and pedestrians were overall at greater risk than occupants. Interventions must therefore: (1) modify the roads to reduce the speed of motor vehicles; (2) create appropriate resources (e.g. shops, schools, playgrounds) to obviate the need of people crossing major highways and roads, and (3) provide effective means for people to cross roads when this is essential.

**Joe Slovo Park.** Sixty two percent of traffic injuries in Slovo Park involved pedestrians. The main risk factor for traffic injuries in the area is the Golden Highway separating Slovo Park from Eldorado Park. This is a 120 km./hr. dual carriageway. Because there are inadequate public amenities in Slovo (e.g. shops, schools), residents have no choice but to cross the highway into Eldorado Park for these services, and in so doing are at risk for being hit by vehicles. There are no appropriately positioned facilities for going over or under the highway, and no devices for slowing the traffic on it. Three main interventions are recommended.

1. Develop shops, schools and other amenities in Slovo Park to reduce the number of

- reasons for crossing the highway.
2. Introduce traffic slowing measures that will reduce the average vehicle speed from the present 120 km./hr. to a maximum of 60 km./hr for the approximately 2 400 metres where the highway runs alongside Slovo Park. These measures could include road mouldings (e.g. corrugations), signage, traffic lights, pedestrian crossings and high visibility colour zones on the road.
  3. Build three pedestrian bridges over the highway to provide accessible crossing places. The positioning of these bridges should be ascertained through weekday and weekend assessment of crossing patterns, and the bridges= design must ensure that they do not encourage assaults and rape by providing cover for perpetrators.

**Nelson Mandela Square.** Transport injuries were evenly spread between pedestrians and occupants, although in the age range 15-24 pedestrians were 2.5 times more frequently injured than occupants, while in the age range 35-44 occupants were more at risk than pedestrians. The most frequent site of pedestrian injury was at the tar roads around the periphery of the camp, and at the time of injury most victims were commuting between home and shops, schools or the transport terminus. Injuries in occurring in the settlement itself were mainly attributed to excessive speeding on the narrow tracks between shacks, often involving the drivers of stolen cars. Three main interventions are indicated:

1. Provision of traffic calming measures and pedestrian crossings on peripheral roads.
2. Provision of traffic calming measures within Nelson Mandela Square.
3. Development of amenities (e.g. shops, schools) within Mandela Square.

**Kersiedorp.** Of the formal housing areas surveyed, Kersiedorp returned the highest incidence of traffic injuries, with pedestrians twice as often victims as occupants. Boundary Road emerged as a high risk zone, owing to the frequency with which children and adults cross it to attend schools, and use shopping and other amenities. Other environmental risks identified were the lack of recreational space for children within the Kersiedorp neighbourhood (leading to children playing on and across the busy roads), and the absence of traffic control and calming measures on Boundary Road and other peripheral roads. Unless total redevelopment of the neighbourhood is contemplated, the housing configuration of Kersiedorp precludes the short-term provision of increased recreational facilities within it. Three main interventions are indicated:

1. Installation of traffic calming measures on peripheral roads, and in particular on Boundary Road.
2. Provision of pedestrian crossings (zebra crossings with traffic lights) at appropriate points on Boundary Road.
3. Provision of improved signage and automatic traffic signals on all peripheral roads.

**Extension 2, Bauhinia Flats.** While returning the lowest traffic injury rates of all six areas, the incidence of traffic injuries in these neighbourhoods was elevated relative to the national average, and well over international norms. Pedestrians were most at risk in Extension 2, while in Bauhinia Flats occupants were injured most often. In both areas the main risk factor for pedestrian injuries was the lack of private and public recreational space. This resulted in use of the streets as a recreational area by children, adolescents and adults, who are thus

exposed to moving vehicles. For all of these areas one major intervention is recommended.

- ❖ The installation of traffic calming measures (speed humps, circles etc.) on all streets in the neighbourhoods and surrounding the flats to ensure that no vehicle can be driven at a speed of more than 50km./hr.

**Other interventions.** Drunk, drugged, and reckless drivers, and speeding by the drivers of stolen cars, were identified as non-environmental risk factors. To alter these requires improved policing to ensure the consistent and continuous enforcement of driver regulations and road laws, and the improved prosecution of vehicle thieves. While desirable, these regulatory interventions require active maintenance by salaried personnel, and are therefore less likely to return sustained prevention success than the environmental interventions described above. They should therefore be regarded as a secondary priority.

### **NON-VIOLENT HOME INJURIES**

Non-violent injuries occurring within the home and in the yard arose from three main categories of cause: Burns, Falls and >Other= causes.

**Burns.** Burns were some six times more frequent in the informal settlements of Slovo Park and Mandela Square than in the four formal residential areas where they accounted for the smallest proportion of household injuries. The following observations and recommendations are therefore restricted to the informal settlements. The main risk factor for burns in the informal settlements was the use of fossil fuels (paraffin, coal and wood) for cooking and heating, with the gallee or mbaolo stove being singled out as particularly dangerous. High risk activities included children playing in the cooking area, unstable implements, and uneven surfaces resulting in the spillage of hot liquids, and direct exposure of the body to flames, steam, and hot liquids while cooking. Two main interventions are recommended to reduce burn injuries.

1. Electrification of Mandela Square and Slovo Park to minimize exposure to poorly controllable heat sources. However, any such intervention would need to occur in combination with housing improvements to reduce the likelihood of secondary risks attaching to electrical fires and electrocution in an inadequate environment.
2. Safety audit of all fossil-fuelled cooking, heating and lighting devices in order to design and promote the use of inexpensive alternatives that can improve safety (e.g. supporting paraffin lamps on a stable base; encourage use of low pressure, wick stoves instead of open fires).

**Falls.** Falls were the leading cause of home injuries in the formal areas and an important cause of injury in the informal areas. Falls occurred most frequently in young children (up to around 10 years of age), and most often took place in the home or yard, followed by the street and play areas. Specific environmental risk factors for fall injuries in children included playing in the home, on steps and on concrete surfaces, as well as falling on broken glass, discarded zinc and other waste materials. Poorly maintained playground equipment at the few public parks and in some schools was also mentioned.

Falls were also elevated among persons aged 60 and over, and occurred almost exclusively within the home. The main environmental risk factors for falls in adults and the elderly was

the design of steps which encouraged slipping (particularly in the flats), and inadequate railings around balconies on multi-storey apartment blocks (one victim sustained multiple fractures after falling from a balcony while drunk). Among the elderly, it must be pointed out that the cases of fall injuries are complicated by osteoporosis (that leads to increased bone fragility), and dementing disorders that can interfere with gait, balance and spatial perception.

There are three main recommendations for the prevention of falls:

1. Safety audit of stairs, stair treads, and railings on all multi-storey council apartment blocks, leading to the appropriate modification of these structures to reduce injuries.
2. Safety audit and modification of all multi-storey apartment balconies and other areas which expose people to unprotected heights.
3. Safety audit and modification of all play facilities for children in public areas and schools, to ensure that equipment and surfaces are made safe, and that glass, zinc and other dangerous waste objects are removed. Wherever relevant, these interventions should also lead to the modification of building codes and standards to ensure that all new housing and recreational facilities conform to these safety standards.

**Other causes.** Other causes ranged from snake and spider bites to cutting the foot with a spade, and were the most frequent cause of home injuries in the informal settlements, and substantially less frequent in the formal areas. The resultant injuries were of less severity than those due to violence, transport, burns and falls. Due to their great variety, Other causes are the most complex to reduce through unitary interventions. For instance, while the use of heavy boots and protective gloves will reduce injuries incurred while digging plants or cutting firewood, it may be financially unrealistic to suggest that shack dwellers all be equipped with such items. That said, it is evident that the upgrading of informal housing to formal settlements with proper services and amenities will markedly reduce the incidence of injuries due to other causes by reducing the number of different injury agents persons are exposed to. Two recommendations are therefore made in respect of preventing injuries due to other causes:

1. Housing and environmental upgrade of Slovo Park and the Nelson Mandela informal settlements.
2. Provision of child and adult education in simple and cheap procedures for improved safety in and around the home.

## VIOLENT INJURIES

While violence was the single largest cause of injuries across the entire sample (accounting for 48 percent of all injuries), it is also the most complex injury cause, and therefore that which is least likely to show a short-term reduction. However, the data for the six neighbourhoods surveyed clearly indicate that violence is less prevalent in formal housing areas where people have been resident for a substantial duration of time and manifest lower levels of related problem behaviour (e.g. morning drinking). This in turn suggests that violence reduction could follow from the development and stabilisation (through job creation, education, and housing) of the informal settlements which returned the highest rates of violent injury, although this cannot simply be assumed. In the light of these comments, what

follow are some suggestions around the prevention of violence, which while lacking the certainty of the previous recommendation may be of some preventive value.

1. The development of neighbourhood counselling and peer support networks to access the 50-60 percent of all victims of violence attacked by intimates and acquaintances. These incidents occur mainly in private spaces that cannot be controlled through visible policing, and the network would provide a possible early escape route for persons who perceive themselves to be at risk for attack.
2. Controls over the time and manner of alcohol sales may effect a substantial reduction in violent injuries, especially in areas with a high prevalence of shebeens. However, alcohol is not only a risk factor for injury, but also an important source of income for many individuals without formal employment. It is therefore likely that attempts to control alcohol sales could provoke strong resentment and even result in violence. That said, the introduction of best practice guidelines for shebeens, and perhaps the provision of cash incentives for the promotion of safe drinking may have some effect.
3. Particularly in the informal settlements where communal toilet facilities require people to walk some distance at night in unlit surrounds, the provision of on site sanitation and the installation of lighting will certainly reduce the number of violent injuries incurred in the course of walking around these areas when answering the call of nature.
4. Visible policing on streets, at transport termini, and at public places may effect some reduction in the 30-45 percent of violence that occurs in such settings. To be effective, this policing should be deployed to target the times and places of highest risk. Of particular importance in respect of place are the informal settlements, which although the most violent areas, currently have no visible policing at all. Other places of risk are the streets, shebeens, open veld, and sports fields. The high risk times of day are between 16h00 and 24h00, with Fridays, Saturdays and Sundays being the most dangerous days of the week.

## CONCLUSION

While the causes of injury show great variations across different neighbourhood types, the magnitude of the injury problem due to both violent and unintentional causes is elevated in areas with poor infrastructures, high-levels of problem drinking and other social and environmental risk factors. Although far from a remarkable discovery, the point of this report has been to suggest how the prevailing rhetoric in favour of information-based safety promotion approaches can be turned into concrete action, even in the absence of formal police and hospital-based information systems. Perhaps most importantly, it suggests that the prevention of violence may be facilitated by the promotion of personal safety in relation to unintentional injuries, in so far as the protection of people from burns, traffic injuries and so on, may produce a heightened sense of personal and communal worth, and a resultant increase in the sense of care for the body and respect for its integrity.

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## **APPENDIX 2**

### **THEMBELIHLE RISK AND RESILIENCY SURVEY**

# **PART THREE**

## **THE CENTRE FOR PEACE ACTION 1990-2000**

### **FROM DEMONSTRATION PROGRAMME TO AFFILIATE STATUS**

**Note: This part three serves as a motivation to gain affiliate WHO Safe Communities Status**

In October 1997, seven years after its 1990 inception with a staff of four, the Centre for Peace Action (CPA) and the Johannesburg South West Metropolitan Council became the 21<sup>st</sup> *Safe Community* demonstration programme in WHO's Global Network of Safe Communities, and the first such programme in Africa. To mark the event, the CPA hosted the *9th travelling seminar on community safety promotion* and the *Sixth International Conference on Safe Communities*, with the theme "Consolidating communities against violence".

The CPA is a partnership between the University of South Africa's Institute for Social and Health Sciences (ISHS), local government, community based organisations, and community residents in suburbs of Johannesburg and Cape Town. It focuses upon the prevention of injuries due to violence and accidental causes in all ages and all social sectors. Since 1990 its safety promotion activities have involved residents of four Johannesburg south-west suburbs, namely Eldorado Park, Ennerdale, Lenasia and Chiawelo. From 1998 onward, in response to local demand for similar demonstration programmes in the Western Cape, the CPA began safety promotion in two communities of the Western Cape's Helderberg district, Rusthof and Nomzamo. In 1998 it also extended its work into another informal settlement, Thembelihle, which is located in Lenasia.

While all of the areas served by the CPA safety promotion activities are low-income residential suburbs, they encompass extreme variations in environmental and living standards, ranging from informal settlements that lack basic amenities such as water and electricity, to rented and privately owned formal housing areas. The CPA is thus well-positioned to explore the effectiveness in different settings of the safe community approach and to act as a test-bed of community-based violence and injury prevention programmes keyed to the life contexts of the majority of South Africans and the many citizens throughout Africa who live in impoverished surroundings. Ultimately any lessons that may arise for best practices in safety promotion may also be considered for replication in various low-to-middle income settings of the southern and northern hemisphere.

A slogan that captures the CPA's orientation to the safe community approach is "Local evidence for local safety". In line with the safe community indicators, the CPA draws upon a combination of qualitative and quantitative data from literature reviews, interviews and epidemiological surveys. This information is used to structure interventions together with the target citizens and other agencies, and through the repeated measurement of individuals and repeated household surveys the CPA attempts to evaluate the outcome and impact of its programmes at the personal and aggregate level. Extending on the public health model and drawing from disciplines such as community psychology, anthropology, sociology and development studies throughout all its programming the CPA upholds the principles of community participation and empowerment; The CPA places particular value on indigenous knowledge systems and on the inter-related concepts of social assets and resilience.

An important safe community criterion, and what is perhaps the key attribute of an affiliate safe community centre, is the programme's dissemination of experiences locally and nationally, and its active contribution to the development of a strong network of safe communities. This presumes the capacity to go beyond the promotion of safety in the immediate catchment area, by helping to develop the capacity of other groups in other places to create and sustain their own community-based safety promotion programmes. In this application for affiliate safe community programme status, the focus is therefore upon the CPA's national and international outreach and capacity-development activities. A separate attachment contains the Centre's annual reports for 1998-2000, each of which describe the day-to-day activities of the Institute and its CPA direct safety promotion programmes for the last three years.

### **CPA's National and International Outreach and Capacity Development Activities**

The CPA operates in close partnership with a social science research Institute, the ISHS of UNISA. In 1995, the ISHS became a WHO Collaborating Centre for Injury and Violence Prevention, and since then has maintained a high level of activity as a regional and global leader in the development of a public health approach to violence and injury prevention in sub-Saharan Africa and other low- to middle-income regions of the world. This has involved maintaining a blend of top-down, national level research and capacity building in areas such as injury surveillance, injury costing and policy development, with bottom-up, community-oriented interventions derived from local level research and local action. In combination, these top-down and bottom-up activities have helped the CPA to become viewed as a *unique national resource* that can act as test-bed for pilot studies of interventions in relation to violence and accidents. The work of the CPA is critical for discerning lessons for **best practices** in the field of injury prevention and safety promotion; lessons that are specifically keyed into the challenges faced by preventionists in low-to-middle income settings such as South Africa.

### **National Outreach and Capacity Development**

As noted in the introduction, the CPA has since 1998 expanded its activities beyond Johannesburg to include two safe community demonstration programmes in the Western Cape. This has substantially increased the visibility of its programmes and with it the number of requests from within South Africa for training and development workshops.

### **Safe schools programmes**

The CPA's safe schools programmes operate in both the Johannesburg and Western Cape target communities. The Johannesburg work has resulted in training and development workshops being delivered on request to teachers, learners and governing boards and the Western Cape work has resulted in requests for feedback workshops from the Western Cape Department of Education. Various governmental and non-governmental groups including the Centurion Town Council have expressed interest in joining a Safe Schools network which could offer research, training and technical assistance. The idea of being designated as a Safe School by our reputable Institute and its CPA carries particular appeal for many in this area.

### **Community-based injury prevention**

The household survey-based Three Neighbourhoods approach to community safety promotion has since 1997 been used to inform the CPA's work in the Western Cape, Eldorado Park and Thembelihle. The CPA's **best practices** team combines the concepts of risk, resilience and social assets in an endeavour to experiment with "What works?" in all of these neighbourhoods.

### **Training of Professionals in Public Health and Community Psychology**

The ISHS participates in the post-graduate training of honours, clinical, counselling, and research psychologists at UNISA. The content of the various courses draws upon many of the CPA's experiences and publications. Three volumes of readings have been published, one a collection of readings for Honours level students, the second a set of case studies and literature reviews of **best practices** for the prevention of crime and violence in South Africa, and the third an edited textbook of original contributions from South African and other authors describing the state of the art of community psychology and lessons for **best practices** for low-income countries. The CPA is registered with the South African Health Professionals Council as a internship training site for research and counselling psychologists. Since 1996 this has led to at least 10 registrations of new professionals thoroughly grounded in the application of research and counselling-community psychology within a safe community context.

Each year the CPA participates in several training courses, targeting public health researchers and practitioners. One such course is the traffic safety and injury control course, which is led by Professor Dinesh Mohan and Dr Geetam Tiwari, from the Indian Institute of Technology based in New Delhi, India.

### **Pilot site for the development of pedestrian injury prevention programmes**

In 2000, as a result of the ISHS's participation in the South African committee of the Global Road Safety Partnership, the CPA became one of two pilot sites for a pedestrian safety intervention. The intervention involves the installation of signage and lighting at dangerous locations on the high-speed perimeter highways around Eldorado Park, and the promotion of wearing among school children of reflective clothing. The project is a cooperative one involving 3M, the national NGO *Drive Alive*, the Council for Scientific and Industrial Research, (CSIR), local government and the local communities.

### **Reference and Resource Centre for Prospective Safe Communities**

Since 1997 the CPA has served as a reference and resource Centre for other South African programmes interested in becoming formal members of the Safe Community network. To date, the most promising candidate is a partnership programme between the Council for Scientific and Industrial Research's transport safety division, the mining house *Billiton*, and communities in Kimberley and Johannesburg. The group have already progressed far with their work in Kimberley in the Northern Cape Province, and are soon to commence the Johannesburg intervention. CPA staff have assisted in their planning and have networked the group with safety promotion researchers in other parts of the world.

### **Newsletter**

Since March 2000 CPA has published *Community Safety News* on a six monthly basis. The newsletter is aimed at capacity development within South Africa and distribution is limited to local and national subscribers. The first issue of a second newsletter, *Africa Safecom*, is also produced and distributed throughout the continent. This newsletter is intended to stimulate discussion about the value of best practices and quality surveillance and epidemiological data.

### **International Outreach and Capacity Development**

While the CPA has actively contributed to the planning committees of all Safe Community conferences since 1997, its main international focus is on the development of community-

based safety promotion in Africa. Currently plans are underway to host the Second Regional African Safecom Conference in Johannesburg (April 4-5, 2001). The theme will be “Community based approaches for injury prevention and safety promotion. Discerning lessons for best practices”.

### **Regional Safe Communities Conference in Zimbabwe, 1998**

The First African Regional Safe Communities Conference took place in Harare, Zimbabwe from 17 to 20 November 1998 and involved 52 delegates from seven countries including Zimbabwe, South Africa, Canada, USA, Philippines, India and Palestine.

### **Pre-hospital Care for Injury Victims: Training First Responders**

Many of the people injured as a result of gunshots, motor vehicle collisions and land mine blasts in Africa are also those with the least access to formal emergency medical services. Consequently, those community members closest to or first upon the scene of injury often render pre-hospital care for this group of victims. These individuals are known as first responders and are a crucial link in the injury prevention chain. In March 1999 the CPA coordinated a week long training course in emergency life support for trainers of first responders. Faculty included Dr. Pierre Bwale of WHO in Geneva, a specialist trauma surgeon from the Milpark hospital in Johannesburg, and senior para-medics from the Johannesburg emergency services. Twenty individuals completed the course, from Burundi, Rwanda, Mozambique, Zambia, South Africa, Egypt, Djibouti, Kenya and Ethiopia. In addition to pre-hospital care, participants were taught about the epidemiology of violence and injury, and their primary prevention through interventions such as Safe Communities.

### **Injury Prevention Initiative for Africa**

The Injury Prevention Initiative for Africa is a Uganda-based programme aimed at developing a public health approach to injury prevention in that country and the central and northern African region. The ISHS has been part of IPIFA since its 1997 inception, where it provides expert input based on the South African experience. This includes the Safe Community work, and as of 2000 the Uganda injury prevention group was developing its community-based intervention with the hope of being formally designated a safe community in late 2001. The CPA provides an important role model for this group, and there is a rich ongoing exchange around development of the Ugandan programme. It is hoped that as similar work starts up elsewhere in Africa the CPA will also be able to assist in programme development.

### **International Injury-Costing Study**

The Karolinska Institutet has coordinated development of a manual for “Cost Calculation and Cost-Effectiveness in Safe Communities”. The first draft was complete in October 2000, and as part of a global field test the CPA will implement it at a number of sites, and has negotiated with the prospective CSIR-initiated Safe Community programme for them to act as a second South African test site.

### **Evaluation: What Value can Affiliate Safe Community Programme Status add to the CPA?**

The CPA is a unique endeavour (not only in South Africa but in Africa more generally), bringing together professionals and community residents around the issue of injury prevention through a combination of community development and public health principles. Affiliate status will consolidate this alliance by identifying the programme with similar

initiatives elsewhere in the world and confirming to its many stakeholders at a local, national and continental level that what they are doing is in line with broader international trends. Designation as an Affiliate Safe Community will enhance the CPA's visibility and strengthen its credibility as an educational and change agent in the field of health policy formulation and injury prevention capacity development. Professional staff of the ISHS are already influential players in the development of South African health policy for injury and violence prevention, and accreditation of the CPA as an Affiliate programme will certainly enhance this policy-making role.

Affiliate Safe Community status will afford an increased opportunity for collaboration and exchange with colleagues from other parts of the world, as was demonstrated when the CPA hosted the *Sixth International Conference on Safe Communities* in October 1997, and thereafter when it coordinated a regional Safe Community meeting in Zimbabwe in 1999. Most recently, it has developed strong links with a safe community group that is developing around the Uganda-based *Injury Prevention Initiative for Africa*, and CPA staff regularly host study visits by local and international safety promotion workers.

Informally, the CPA has for the last two to three years operated as an Affiliate Safe Community Programme, and its staff are confident that formalisation of this status will reinforce the organisation's identity and their sense of purpose as safety promotion workers in one of the world's most dangerous regions. The formal affiliate designator will facilitate the Institute and its Centre's move from a national to a continental level resource.

**CENTRE FOR PEACE ACTION  
WORLD HEALTH ORGANISATION  
SAFE COMMUNITIES DEMONSTRATION PROGRAMME  
AND  
AFFILIATE SUPPORT CENTRE**

As a WHO Affiliate Safe Communities Support Centre we envisage operating at national, continental and international levels.

On the **national and continental fronts** we endeavour to:

- ❖ Assist communities in the preparation and submission of their applications for Safe communities status;
- ❖ Provide on-going technical and training assistance to Safe communities operating in the sector;
- ❖ Assist Safe community programmes to develop their research and injury prevention capacities;
- ❖ Confer Safe communities status to worthy communities operating on the African continent; and
- ❖ Help designated communities maintain and develop their status by way of regular and supportive reviews and quality assurance inputs.

At the **international level** our role is to:

- ❖ Stimulate interest in issues affecting injury prevention in low to middle income contexts;
- ❖ Facilitate relevant exchanges in the form of research collaborations, capacity building and exchange programmes;
- ❖ Encourage mutually beneficial research between those working in low/middle income and high income contexts; and
- ❖ Disseminate information on best practices for injury prevention and safety promotion.

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**SAFE COMMUNITIES  
AFFILIATE PROGRAMME  
APPLICATION**

**Submitted by:**

**Institute for Social and Health Sciences  
and  
Centre for Peace Action**

# TABLE OF CONTENTS

## PART

<b>ONE.....</b>	<b>1</b>
<b>1 BACKGROUND AND OVERVIEW.....</b>	<b>2</b>
1.1 INTERNATIONAL EXCELLENCE.....	2
1.2 CONTEXT FOR KNOWLEDGE PRODUCTION: TERMS OF REFERENCE AND ASSUMPTIONS.....	2
1.3 ORIENTATION AND SCOPE.....	3
<b>2 MAGNITUDE OF INJURY PROBLEM AND RESEARCH GAPS.....</b>	<b>4</b>
2.1 THEORETICAL FRAMEWORK.....	6
<b>3 OBJECTIVES.....</b>	<b>7</b>
3.1 SPECIFIC OBJECTIVES.....	7
3.2 SPECIFIC OBJECTIVES.....	9
3.3 SPECIFIC.....	12
3.4 SPECIFIC OBJECTIVES.....	13
<b>PART TWO.....</b>	<b>20</b>
<b>4 BACKGROUND: THE CENTRE FOR PEACE ACTION: MISSION AND VISION.....</b>	<b>21</b>
<b>5 INTRODUCTION: THE SAFE COMMUNITY INDICATORS.....</b>	<b>21</b>
<b>6 ELDORADO PARK AND THE CENTRE FOR PEACE ACTION: A SAFE COMMUNITY?.....</b>	<b>22</b>
<b>7 THE SAFE COMMUNITY INDICATORS RELATED TO THE CPA.....</b>	<b>25</b>
7.1 THE EXISTENCE OF A CROSS-SECTORAL GROUP RESPONSIBLE FOR INJURY PREVENTION.....	25
7.2 INVOLVEMENT OF THE LOCAL COMMUNITY NETWORK.....	29
7.3 A PROGRAMME COVERING ALL AGES, ENVIRONMENTS AND SITUATIONS.....	30
7.4 THE PROGRAMME MUST SHOW CONCERN FOR HIGH RISK GROUPS AND HIGH RISK ENVIRONMENTS AND AIM PARTICULARLY AT ENSURING JUSTICE FOR VULNERABLE GROUPS.....	32
7.5 THOSE RESPONSIBLE MUST BE ABLE TO DOCUMENT THE FREQUENCY AND CAUSES OF INJURIES.....	32
7.6 THE PROGRAMME MUST BE A LONG-TERM PROGRAMME RATHER THAN A SHORT-TERM PROJECT.....	32
7.7 UTILIZE APPROPRIATE INDICATORS TO EVALUATE PROCESSES AND THE EFFECTS OF CHANGE.....	32
7.8 ANALYSE THE COMMUNITY’S ORGANIZATIONS AND THEIR POSSIBILITY OF PARTICIPATION IN THE PROGRAMME.....	33
7.9 INVOLVE THE HEALTH CARE ORGANISATION IN BOTH REGISTRATION OF INJURIES AND THE PREVENTION PROGRAMME.....	33
7.10 BE PREPARED TO INVOLVE ALL LEVELS OF THE COMMUNITY IN SOLVING THE INJURY PROBLEM.....	34
7.11 DISSEMINATE EXPERIENCES BOTH NATIONALLY AND LOCALLY.....	34
7.12 BE PREPARED TO CONTRIBUTE TO A STRONG NETWORK OF SAFE COMMUNITIES.....	35

**APPENDIX**  
**1.....36**

**METHODOLOGY.....37**

**A NEIGHBOURHOOD INJURY PROFILE.....37**

**IMPLEMENTATION.....42**

**RECOMMENDATIONS FOR IMPROVING**  
**SAFETY.....43**

**TRANSPORT RELATED**  
**INJURIES.....43**

**NON-VIOLENT HOME**  
**INJURIES.....45**

**VIOLENT**  
**INJURIES.....46**

**CONCLUSION.....4**  
**7**

**REFERENCES.....4**  
**8**

**APPENDIX**  
**2.....49**

**PART**  
**THREE.....**  
**50**