

INJURY BULLETIN

Queensland Injury Surveillance Unit
No 93 September 2006

QJSU collects and analyses data from emergency department injury presentations on behalf of Queensland Health. Participating hospitals represent three distinct areas of Queensland.

QJSU publications and data are available on request for research, prevention and education activities.

HOSPITALS:

Mater Children's, Mater Adult, Princess Alexandra, Redland, Logan, Royal Children's, Mount Isa, Mackay Base, Mackay Mater, Proserpine, Sarina, Clermont, Dysart, Moranbah and Mareeba.

QJSU STAFF:

Director – A. Prof. Rob Pitt,
Paediatric Emergency Director,
QJSU Director, Mater Children's Hospital
Manager – Debbie Scott
Data Analyst – Richard Hockey
Marketing/Safe Communities Manager – Dawn Spinks
Paediatric Emergency Specialist-
Dr Ruth Barker / Dr Mike Shepherd
Coding /Admin –
Patricia Smith, Linda Horth
Bulletin Layout-Patricia Smith

Contact QJSU:

Level 2
Mater Children's Hospital
South Brisbane 4101
Phone 07 38408569
Facsimile 07 38401684
Email mail@qisu.org.au
URL www.qisu.org.au

ISSN 1442-1917

QJSU is funded by
Queensland Health
with the support of the
Mater Health Service
Brisbane

No 93 September 2006

WHO Safe Communities: 20 years on.

Dr Ruth Barker, Dawn Spinks

Introduction

The concept of "Safe Communities" evolved following a successful community based injury prevention project in Falköping, Sweden in 1974. The premise of this concept draws from community development models and maintains that communities are best placed to develop and implement local solutions for local injury risks. Whilst environment and behaviour have long been accepted as predeterminants for disease the challenge has been to expand this understanding to include injury.

The Safe Communities concept was presented at the First World Conference on Accident and Injury Prevention held in Stockholm, Sweden in 1989 and has since been adopted by the World Health Organisation as a strategy for promoting safe living environments and reducing injury at a community level. WHO supports an accreditation process through the Karolinska Institute for communities wanting WHO safe community status. The Safe Community strategy includes six key programme indicators that are required for WHO accreditation:

1. An infrastructure based on partnership and collaborations, governed by a cross-sectional group that is responsible for safety promotion in their community;
2. Long-term, sustainable programmes covering both genders and all ages, environments, and situations;
3. Programmes that target high-risk groups and environments, and programmes that promote safety for vulnerable groups;
4. Programmes that document the frequency and causes of injuries;
5. Evaluation measures to assess their programmes, processes and the effects of change;
6. Ongoing participation in national and international Safe Communities networks.

Currently there are 101 designated WHO safe communities representing populations from 1,000 to 1,000,000. The majority are Scandinavian communities, but the model is increasingly being taken up in Canada, China, South East Asia, Australia and New Zealand¹

However, despite nearly two decades of experience with this strategy, strong evidence of its success in reducing injuries in the community is lacking. A Cochrane review: "The WHO Safe Communities" model for the prevention of injury in whole populations: conducted in 2005, revealed that only seven WHO Safe Communities, of the then more than 80 worldwide, had "undertaken controlled evaluations using objective sources of injury data."²

The authors concluded that "evidence suggests the WHO Safe Communities model is effective in reducing injuries in whole populations. However, important methodological limitations exist in all studies from which evidence can be obtained. A lack of reported detail makes it unclear which factors facilitate or hinder a programme's success"².

So what do we mean by success? And are we measuring the right things?

So far, success in most Safe Communities programmes has been measured by process and impact, with very little outcome data. A few communities have demonstrated a measurable decrease in injury rates; however this has not been maintained over time.³ Although reduction in injury is the ultimate goal, process and impact is equally important. Safe Communities has a broader perspective than traditional injury prevention programmes. For a community to function at its optimum level, perceptions of safety, risk management procedures, relationship development and information exchange need to be addressed. A successful Safe Community needs to pay as much attention to process and impact as it does to outcome in developing a programme that is effective and sustainable.

What makes a Safe Community?

To date the published literature about Safe Communities has raised more questions than it has answered. Researchers have attempted to identify features of a successful Safe Community programme through post hoc analysis of published Safe Community programmes and by gathering additional information from programme co-ordinators.⁴ However, analysis has concentrated on large, well documented Scandinavian/Canadian Safe Communities, and conclusions drawn from these studies do not necessarily reflect the experience of Safe Communities in other countries.

The following is a review of the proposed features of a successful Safe Community and how they relate in an Australian setting.

What is a community?

"A Safe Community is one in which all sectors of the community work together in a coordinated way, forming partnerships to promote safety, manage risk and increase the overall safety of its members."^(5 Craig)

Community can be defined in terms of geographical, structural, social, economic, cultural, occupational and political boundaries. To date the majority of Safe Communities have defined their populations on a geographical basis (town, city, municipality or county). In part, there is a bias associated with Safe Community designation. Substantial funding is required to achieve WHO accreditation, limiting this process to well resourced communities. Rural or remote communities and alternative communities such as schools, childcare facilities, hospitals or cultural groups may not be able to afford accreditation, although this cost may be reduced with the increasing trend towards local accreditation through the Australian Safe Communities Foundation (ASCF) or the Queensland Safe Community Support Centre (QSCSC).

Community cohesion

Several authors have suggested that cultural homogeneity is important for success of Safe Community programmes.^{6,7} In the true "bottom up" design of Safe Community programmes, co-operation between representatives of a community is important. However, community members from diverse cultural backgrounds may agree on priorities and strategies to reduce injury, where other more like-minded individuals may not. Communities may appear "cohesive" to outsiders yet be internally divided. In Australia, many geographically or otherwise defined communities comprise people from diverse cultural, educational,

political and social backgrounds. In particular, Aboriginal communities, often "easy" to define by their remoteness and isolation are fluid, multicultural communities based around distinct language and family groups with disparate agendas. Yet even in these "heterogeneous" communities, community interventions such as cultural programmes and night patrols have served to reduce violence and injury in the community.⁸ This is a major benefit of safe communities – bringing like and diverse minds together to create useful and lively debate, to respect similarities and differences and work together to promote a safe and healthy community.

Corporate Communities

There is increasing recognition that corporations influence our financial, social, political and structural environment. In the simplest sense, a corporate community can be defined as those who work within the corporation. Traditionally, health and mining/construction corporations have been most focussed on health promotion and injury prevention strategies in their workforces. This focus is expanding as corporations are increasingly driven by the triple bottom line of the financial, social and environmental impact of their actions. Corporate communities may also be defined in terms of their broader sphere of influence (economic, environmental, marketing, brand identity). In a climate where corporate responsibility and accountability attracts economic investment, there is increasing scope for corporations to throw their financial weight behind Safe Community strategies. Promoting well being, risk management processes and injury prevention activities in the communities they develop and from which they source their staff will result in a more focused, productive and satisfied environment in which to live, work and play.

Identifying programme targets

A key Safe Communities indicator is to develop programmes that target high-risk groups and environments, and programmes that promote safety for vulnerable groups. There are many ways to tackle this by looking at:

- Injuries that effect specific groups (for example, by age, by gender)
- Injuries that happen in specific settings
- Injuries that happen during specific activities
- Injuries that happen to specific body parts
- Injuries that are preventable with simple measures
- Injuries that are preventable with complex multifaceted measures
- Injuries that affect the community in terms of social dysfunction, cost, rehabilitation, resources etc

In any given community, different structures within the community will make some targets more "do-able" than others.

Multifaceted intervention strategies

Traditional health promotion strategy suggests that public health interventions should be multifaceted, targeting populations in many ways. An example of this would be the "Slip, Slop, Slap" campaign which for many years has maintained a broad media profile with the Australian public, heightened melanoma surveillance and research within the medical community and lobbied for long term policy change as has occurred within Australian schools ("no hat no play" policy). This

multifaceted approach relies on the premise that targeting an issue in many different ways compounds the positive effect through reinforcing the desired health message. With regard to Safe Communities, several authors have claimed that multifaceted intervention strategies are a prerequisite for success.^{6,7} There exists a significant bias in that larger and better funded Safe Communities have both a greater potential for multifaceted interventions and for programme evaluation. In smaller communities multifaceted approaches can drain limited resources (human, financial) and may lessen the overall impact of the programme.

Community priorities versus evidence based interventions

The main premise of Safe Communities is that individual communities are best placed to identify safety issues and implement solutions that are appropriate to their community. However, communities may require outside impetus, funding, political co-operation and objective evidence to fuel the process. In the community development model, intervention strategies are "bottom up", based on community identified priorities rather than those of external bodies (health, government). This is believed to engender ownership of the identified problem and solution strategy and facilitate acceptance and long term change within the community. However, in attempting to identify areas for intervention, communities are appreciative of evidence (injury data, health statistics and police data) and strategies (programmes that have worked in other communities) that may help to develop interventions within the community.⁹

Several authors have suggested that to be effective, a Safe Community programme needs to be informed by evidence rather than relying on community identified priorities.^{6,7,10} This is fine if the community owns the data. However, if the data is given by outside sources, this may be seen by the community as a "top down" approach with external bureaucrats dictating community behaviour. A balanced approach would involve a combination of strategies, with communities targeting identified priorities yet being informed and potentially assisted by external data, campaigns and policies.

Whilst Safe Communities is about addressing injury issues at local level, quite often this requires lobbying at state and federal level for assistance, support, and even in some cases legislative changes. For example; Townsville has a highly transient community; so in order to address problems related to alcohol consumption, programmes would have to be continually delivered to the ever changing population. This is unsustainable in the long term and a waste of resources. However, if the state and federal governments were to implement a related program or campaign on a state or national level, the heat would be removed from the resources at the local level and could be redirected to enhancements of the national/state campaigns. This maximises everybody's investment and also provides a consistent and credible message. Documents such as the National Injury Prevention and Safety Promotion Plan (2004 – 2014) can assist in this manner.¹¹

A word of caution is needed. Safety has a different meaning to different individuals and communities. The Geneva Convention and the Ottawa Charter address

the fact that safety is a basic human right. But this needs to be linked with **Maslow's Hierarchy of Needs**

- Self Actualization Needs (full potential)
- Ego Needs (self respect, personal worth, autonomy)
- Social Needs (love, friendship, comradeship)
- Security Needs (protection from danger)
- Physiological Needs (warmth, shelter, food)

For some, this translates to the most basic level of food, shelter and warmth. The next level is security needs/ protection from danger. As people progress through the levels of personal development defined by Maslow, it is clear that for a person to reach their full potential they must also develop their sense of self respect, and healthy relationships. This is what makes up a healthy community – individuals striving to attain self actualisation.

Not surprisingly, because of different physical, political and cultural issues in different countries and different communities within countries, programmes implemented in one place do not necessarily translate easily to another community, if at all. For example, countries and communities enduring war conditions have to attend to the lower level needs first.

Evaluating Safe Communities

By measuring injury rates, process and sustainability, a Safe Community is able to share information and experience with other communities in a meaningful way. Thorough evaluation enables successful programmes to be replicated / modified for other communities to use.

Injury data

Surveys that are available on Safe Communities reveal one reason behind the paucity of well evaluated Safe Community programmes in the literature. Most programme co-ordinators reported that they had little or no injury surveillance data available.¹⁰ What data was available was often not used to inform programme interventions.

Without reliable injury data, it is impossible to adequately evaluate Safe Community interventions in terms of reduction in injury. Whilst programme evaluation in terms of process, community acceptability, sustainability and perceived community safety is equally important, reduction in injury rates and severity is also a key indicator of a programmes success.

Injury data comes from many sources (hospital admission data, death data, police, fire and ambulance data, emergency department data). This data can be difficult to access and may not relate to the targeted injury group. An injury surveillance system provides an **integrated process for monitoring injury rates within a community**. The surveillance system data can be used both to inform programme development and to assist in programme evaluation. It also provides the opportunity to create positive and meaningful feedback to the community about tangible effects from the intervention selected.

Those communities that do have baseline data are better positioned to serve their community by identifying key injury issues and developing programs at a community level which will reduce these injuries. Having real local data, which illustrates the success of the efforts of all involved, breeds community confidence and ownership and empowers the community toward looking after itself. This contributes significantly to the multivariate approach to developing a safe community, one in which

we all have the right to feel safe and develop strategies in order to achieve that state.

Social Network Analysis

Partnerships, perceptions of risk and safety, sense of empowerment; all of these factors impact on our behaviour and potential risk of injury. These are crucial elements in the evolution of a Safe Community and therefore warrant evaluation. Partnership analysis tools and social network analysis tools are being developed in order to identify effective partnerships and relationships to maximise outcomes and best use resources.⁹ These tools also help inform management and working groups about effective time investment.

Training

Another key issue with evaluation is training. Most public health practitioners are not trained in evaluation techniques. Encouraging universities and key organisations such as QSCSC to provide accessible training courses and to partner with the Safe Communities will promote the viability of effective evaluation processes for community interventions.

A Change in Thinking

How often have you heard 'do not compare apples with oranges'?

It is so true.

Just as the thinking behind safe communities has developed over the past 20 years, so too has the thinking behind evaluation. Yes, we do need 'hard' outcomes translated as quantifiable reductions. However, the term 'soft' outcome is misleading. People, usually clinicians, academics and epidemiologists use this term to imply 'a lesser than' measure, one that is less important. In the year 2006, we need to challenge that thinking and consider the equal importance of both measures when we are referring to communities – the very structure that marks where and how we live.

Sustainability

Perhaps the greatest challenge for Safe Communities is Sustainability. Programmes need to be developed with long term solutions.

Funding

Funding is a key issue. Accessing and maintaining funding sources is challenging, time consuming and requires a dedicated approach. Programmes dependent on government funding are vulnerable to changes in the political climate. Safe Communities programmes have to be more robust.

Evidence has shown that communities which have relied on government funding alone to develop and sustain their programmes have not been successful.

"The future sustainability of the Harstad Program seemed threatened by the fact that government resources stopped at the end of 1994! The same thing happened in Falkoping in 1982 when the county funding was withdrawn: when there is no activity - there is no effect!" (12, Borge Ytterstad, Leif Svanstrom)

Partnerships

Safe communities will only be sustained if we help identify and partner with corporate entities that share the underlying philosophy that safety and security are

a basic human right and that they have the responsibility and are in a pivotal position to support these processes across the generations.

Partnerships need to be developed in order to maximise the opportunities for long lasting programs. To have a chance of success, programmes need to address the following components:

- Evidence/ Epidemiology
- Engagement
- Empowerment
- Enforcement
- Education
- Engineering
- Evaluation
- Economics

Addressing these components requires expertise and influence over a broad area. This is beyond the capacity of any one person/ organisation. Programmes which fail to address these components fail to maintain their impact! What a terrible waste – having found what works, stopping it – and moving to something else. That cannot make sense in any person's language!

Accreditation

The WHO Safe Communities program offers communities an established model for becoming a Safe Community, with six indicators to guide the programme development. The accreditation process through WHO is rigorous. In Canada there is an option for a more local, tailor made set of criteria for local communities to be accredited as a 'Canadian Safe Community'¹³

Potential safe community stake holders often debate the benefits of WHO accreditation compared to a state or national accreditation. This may also reflect the different stakeholder type as those with only state or national affiliations may choose to keep their processes 'local' while those with international connections may benefit from international accreditation.

In Australia there is currently discussion within both the Australian Safe Communities Foundation (ASCF) and the QSCSC to develop a local accreditation process.

Whatever the community chooses, (usually dependent on the key drivers of the programme), it is important that the process is not cumbersome and that there is understanding that once accreditation has been achieved, the community needs to continue their activities in order to maintain the status. Maintaining accreditation status requires ongoing attention to the E's in a potentially changing environment. Flexibility and innovation may be needed over time.

Injury Surveillance in Queensland

The Queensland Injury Surveillance Unit (QISU) has been collecting, analysing and disseminating injury surveillance data in Queensland for over 20 years. All data is collected through participating hospital emergency departments. At present 16 sites are participating in data collection. Data is collected through one of two mechanisms. Electronic data is collected and coded at triage at sites using the EDIS (emergency department database system). Sites not using this system collect paper records and injury data coding occurs at the Injury Surveillance Unit.

QISU collects level 2 injury data (NDS-IS level 2) which codes for various factors including age, sex, type of

injury sustained, mechanism of injury, where the injury took place, injury severity etc. All data is de-identified. Data is stored and retrieved for data analysis on request. In addition, QISU produces regular injury bulletins describing injury patterns in Queensland and detailing preventative strategies. This is a powerful tool for communities to get a snapshot of the incidence of injury in their community and then request more detailed reports on injuries of particular interest. For example, QISU has produced reports for collecting communities which identified bicycle injuries. As a result, council increased their budget to allow for more and improved bike paths¹⁴. Mackay and Mt Isa used local data to baseline child injury profiles^{15,16}. For those communities in Queensland who do not collect local injury surveillance data, QISU has representative data in remote, provincial and metropolitan Queensland. However, collection at the local hospital is preferred to provide local data to inform local interventions and change.

Safe Communities in Queensland

Currently, there are two designated WHO Safe Communities in Queensland: Mackay/Whitsunday and Toowoomba, with another, Townsville and Thuringowa, due to receive their accreditation in October 2006.

There are a number of other communities in Queensland that are currently working towards their accreditation

The Role of the Queensland Safe Communities Support Centre

The QSCSC was established after significant consultation with government organisations and safe communities (see options paper at www.safecommunitiesqld.org¹⁷)

The key roles of the centre are to:

- Communicate the essential features of a Safe Community
- Assist collaboration and capacity building within communities
- Assist communities to develop and sustain their Safe Communities programme
- Identify and develop partnerships
- Support networking between communities
- Assist communities to access data to enable communities to profile their injury burden and proceed with programs on an evidence base
- Advocate on behalf of Safe Communities
- Assist communities to identify resources
- Assist with communities accreditation toward WHO Safe Communities
- Consider the development of state/national accreditation indicators.

The Centre is a non government, charitable organisation and therefore independent of any particular government agenda. Initial funding was supported by the Mater Foundation and the intention was/is to

seek combined corporate and government funding in order to resource the Centre.

Safe Communities is not pyramid selling – it is not about getting numbers of safe communities for numbers sake. It is about quality and genuine vision and interventions. It is about informing, learning and sharing information with key players, who have a shared goal toward making Queensland a safer place to live, work, travel and play. To this effect, QSCSC organises an annual conference; the second annual conference will be held in Townsville on October 12 and 13, 2006.

The QSCSC is dedicated to identifying partners who recognise the benefits of the Safe Communities approach guided by the WHO indicators. In this way, the QSCSC aspires to identify partners who can help resource a funding bank which in turn can assist less resourced community programmes

Closing the loop - Queensland Injury Surveillance Unit and Safe Communities

The Safe Communities Support Centre and QISU are a natural fit. In encouraging communities to access local data for local issues, meaningful injury prevention projects can be developed and evaluated. Sixteen hospitals in Queensland collect injury surveillance data and therefore have access to data and reports about specific injury profiles in their communities. This information also helps inform the media and acts as an advocacy tool for encouraging awareness and change. However, some hospitals that do have access to the EDIS system choose not to turn on the injury screen. What a waste of a rich data source that is really owned by the community, yet held back from them due to resource limitations or perhaps a lack of understanding of the power of such data in creating real and positive changes within the community!

The Future

Where is Safe Communities heading – does it have a place?

It is an essential human right to be safe. Therefore, yes, Safe Communities has, and will have, a central place in the lives of people provided that our approach to Safe Communities remains relevant to our evolving communities. Before Safe Communities can be widely adopted there needs to be cultural and philosophical shifts to accept the following:

- Safety is everyone's business
- We are all responsible to contribute to being safe
- Some of us are in a more influential position than others and need to take that position seriously
- Safety is different for different people
- Safety is not just the absence of something, but is a multifaceted concept and sense of being which, as humans, involves issues of perception and reality
- Safety is about generational change
- Safety is about sharing knowledge
- Safety is about doing what we can do best – and not trying to do it all

If environment and behaviour are accepted as predeterminants for injury, then the continuing challenge is to develop this further and include risk management, risk and safety perceptions and social capacity to create safer communities.

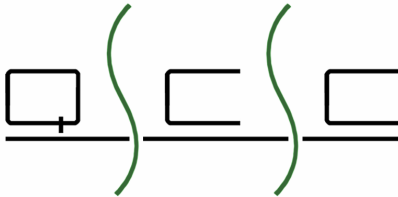
The role of organisations such as QISU and QSCSC is to help proliferate these concepts via partnerships, information sharing and training and translate them into meaningful change for individuals in all communities, one community at a time.

References

1. www.phs.ki.se/csp/who_safe_communities_network_en.htm
2. Spinks A, Turner C, Nixon J, et al. The "WHO Safe Communities" model for the prevention of injury in whole populations. Cochrane database Syst Rev, 2005a, Issue 2. Art No: CD004445, Pub 2. DOI: 10.1002/14651858.CD004445.pub2.
3. Svanstrom L, Schelp L, Ekman R, et al. Falköping, Sweden, ten years after: still a safe community? International Journal for Consumer safety. 196; 3:1-7
4. Nilsen P, Hudson D, Gabreilsson F, et al. Strategies and goals of community-based injury prevention programmes- a mixed-methods study of 25 Scandinavian WHO Safe Communities. International Journal of Injury Control and Safety Promotion. March 2006, 13(1):27-33
5. www.nsh.nsw.gov.au/HealthInfo/HealthProm/events/SafeComm/Adam%20Craig_BuildingASafeCommunity.pdf
6. Nilsen P. What makes community based injury prevention work? In search of evidence of effectiveness. Injury Prevention. 2004;10:268-274
7. Nilsen P. The theory of community based health and safety programs: a critical evaluation. Injury Prevention. 2006; 12:140-145
8. Clapham K. Injury Prevention Activity Among Aboriginal and Torres Strait Islander Peoples Project Report. Volume II: Programs, Projects and Actions. Report to the Australian Department of Health and Ageing. August 2003
9. Allegrante J P, Marks R, Hanson D. 2006, Ecological Models for the Prevention and Control of Unintentional Injury. Carlson Gielen A, Sleet D A, DiClemente R J. Injury and Violence Prevention: Behavioural Science Theories, Methods and Applications, Jossey-Bass, 105-126
10. Nilsen P, Bourne M, Coggan C. Using local injury surveillance for community-based injury prevention: An analysis of Scandinavian WHO Safe Community and Canadian Safe Community Foundation programs. thesis accessed at <http://www.diva-portal.org/liu/theses/abstract.xsql?dbid=7001>
11. National Injury Prevention and Safety Promotion Plan (2004 – 2014) [http://www.dhs.vic.gov.au/nphp/publications/sipp/nipspp.pdf#search=%22National%20Injury%20Prevention%20and%20Safety%20Promotion%20Plan%20\(2004%20E2%80%93%202014\)%20%22](http://www.dhs.vic.gov.au/nphp/publications/sipp/nipspp.pdf#search=%22National%20Injury%20Prevention%20and%20Safety%20Promotion%20Plan%20(2004%20E2%80%93%202014)%20%22)
12. <http://www.rhpeo.org/ijhp-articles/e-proceedings/nordic97/61.htm>
13. <http://www.safecommunities.ca/>
14. Personal communication . Dr Dale Hanson. Mackay

Whitsunday Safe Communities.

15. http://www.qisu.org.au/modcore/PreviousBulliten/backend/upload_file/issue077.pdf
16. http://www.qisu.org.au/modcore/PreviousBulliten/backend/upload_file/issue078.pdf
17. <http://www.safecommunitiesqld.org/modcore/Publications/frontend/index.asp#a28>



**Queensland Safe
Communities Conference
'BUILDING BLOCKS'**

**12 and 13 October 2006
Jupiter's Casino, Townsville**

Program and registration details
www.safecommunitiesqld.org

