Introduction

The traditional view of injuries as “accidents” or random events, had resulted in the historical neglect of this area of public health. Among the most challenging problems in the next century will be to decrease the burden of accidents and injuries [1]. Nowadays, a large share of health care resources in developed and developing countries are consumed for unintentional injuries [2, 3]. Despite this, every year, nearly 5 million people dies due to injuries of that 24% was related to traffic injuries, 18% Unintentional events, 16% suicide and 14% falling[4-6].

Regarding, there are good reasons for all nations in the world to prioritize injury prevention and safety-promotion programs. Some local-government units in developed and developing countries have begun community actions which had led to safe communities [7, 8]. Community interventions are distinguished by a shift in focus away from individual responsibility towards multi-faced community-wide interventions designed to ensure that everyone in a community was involved [9]. Experience
showed that in successful community programs there was only a short lapse between the start of prevention and control measures and a decrease in the injury rate. Such rapid reward encourages community participants to continue their efforts [10]. When this is demonstrated, safety measures can generally gain broad public support and may then effectively be promoted by media. It has often been stated that the Safe Community Movement has its roots in the Swedish local injury-prevention programs, such as in Falköping, Lidköping and Motala, developed during the 1970s and 1980s [11]. This is only partly true. Policy-wise the Safe Community Movement goes back to the development of health-policy movements like “New Public Health”, the World Health Organization’s “Health for All” strategy, and the Ottawa Charter [12].

A safe community was introduced as an attractive place to live and work. In a safe community people could have their daily activities without harm, risk or fear [13]. Using local capacities, safe community model tries to prevent injuries in the community [14]. As injuries was an important challenge for communities, this model was promoted in different countries which are evaluated and designated as a safe community through some indicators by WHO collaborating center for community safety promotion, karolinska, Sweden. Designated safe communities represent their activities report in their webpages presented at WHO collaborating center for community safety promotion web.

Considering that not only webpage design and reporting the activities in it, is one of the evaluation criteria, but also it helps for benchmarking and knowledge and experience transfer for other interested communities. Regarding the safe communities’ webpages information is important. On the other hand, a quantitative analysis of safe communities’ activities is needed to highlight the differences between communities. Analysis of the communities’ activities during the time and comparing in periods, would show the safe communities movement line and lead to safe community model improvement. Despite the studies reporting the safe community effects on injury prevention and its managerial aspects, almost no studies had considered a web and reporting based evaluation of the safe communities. This study aimed to provide a baseline assessment of safe communities’ activities and performance based on saved webpages of designated communities in 2005.

Methods

Using descriptive and analytic design this study conducted in 2005, including all 65 designated and active safe communities. Data were extracted using designated safe communities webpages (saved in 2005) presented in the WHO collaborating center for community safety promotion website [15]. A designated safe community is a community which had implemented some interventions to promote community safety and met the criteria developed by WHO collaborating center for community safety promotion [15]. Every community was designated for 5 years and must be re-designated.

A special questionnaire (goal-driven) was designed to fill in the data about different safe communities and finally entered into an access database and analyzed by SPSS 20 statistical software. Main variables were considered to be country of the safe community, population, age of the community, publications, different intervention places and groups, international commitments and participation in safe community conferences.

Frequency tables and graphs, Pearson Correlation and chi-square tests were used to analyze data. This study provides a baseline assessment to study the safe communities periodically.

Results

Results revealed that there were 65 active designated safe communities from 16 countries of which 56.25% were located in Europe. The greatest number of safe communities belonged to Sweden, Norway and Australia respectively. Only three communities comprising 4.6% of all the safe communities were located in Asia (Table 1).

Moreover, 26.2% of safe communities had started their activities before 1990 and 92.3% had started their activities before 2000. Histogram for age of communities from starting their activities is given in figure 1.

The mean length of time for activities of the safe communities after their first designation was 11.3 years. Nearly all of the designated safe communities had specific injury prevention programs for different age groups and 49 (75.4%) of them had programs for high risk groups, as reported in their webpages.

In case of intentional injuries, 73.8% of the designated safe communities had reported having some programs or activities or ideas for violence prevention and 49.2% was the figure for suicide prevention. Activities in the field of occupational safety promotion was higher in Sweden compared to other countries. Observed difference was statistically significant by chi-square test (P<0.01) (Table 2).

92.3% of safe communities had declared in their webpages to have some kind of injury surveillance. Nearly 74% of safe communities had declared to have publications. A total of 17 theses, 23 books and 71 journal articles (either local or international) and 542 other kinds of publications were the result of safety promotion activities in different safe communities. The highest number of publications (including pamphlets and other forms of educational materials, n=150) belonged to Fyn community in Denmark. Although no books or journal articles were released by this community, six theses worked in field of safety promotion belonged to this community. The second safe community in this regard after Fyn was Motala community in Sweden (88 publications). With respect to scientific publications comprising journal articles, books and theses, Motala community had the first rank in number of publications (n=34).

The entire 71 published journal articles belonged to only 10 safe communities, 39 out of these produced only in four of the safe communities from Sweden. Mean total number of various publications, including pamphlets, for each safe community was 10.1 and its standard deviation was calculated to be 22.1 articles. Calculated Pearson correlation coefficient was not statistically significant for the relation between age of the safe community and number of books published, but it was significant for the relation of age of the community and number of theses...
publication \((r=0.55, p<0.05)\). The correlation coefficient was 0.42 for number of other publications and 0.34 for the number of articles published in journals, both of these being statistically significant.

The highest population was around 2000000 people in Dallas safe community in the USA and the lowest was 1400 in Corkerhill safe community in Scotland. Mean population of the designated safe communities around the world was about 147900.

A mean number of five staff were reported to work in each safe community. Mean number of international commitments was 1.87 for receiving or paying visits, 2.98 for participations in Safe Community conferences and 0.4 times for hosting Safe Community conferences or meetings.

**Discussion**

Developing countries, although in urgent necessity, had a small share of world safe communities [15]. This may not be merely because of the international support or limitation of recourses, but maybe because of lack of sufficient health and safety insight among governments and policy makers of these countries. Moreover, as was released in safe community principles, the movement must be on the local resources, networks and cross-sectoral actions which are in a weak status [16]. It may be a great surprise that Japan contrary to its achievements in improving its health indices, had not shown to be a premier in field of safe community movement. According to WHO declaration (1994), each year nearly 100 million workers are injured and 200000 die due to occupational accidents [17]. It seems that many safe communities except Sweden, had not been much active in the field of occupational safety promotion, however, this needs further research to elaborate it. While developed countries through improving management and safety culture, have reduced the number of occupational injuries, it had an increasing trend in developing countries [18]. There is a great diversity in population bases of safe communities and the difference range is very wide and leaders of communities such as Dallas may need some reconsiderations in their strategies.
Data given in webpage of some safe communities are quite insufficient and in some cases very ambiguous. It seems that many of the safe communities must increase the availability of their documents and performance reports. Although many safe communities have reported in their webpages about their activities in field of suicide prevention, most of such activities seem not to be noticeable.

More attention must be paid on using approved scientific methods in decision making for safe community strategies and scientifically publishing experiences for facilitating management bench-marking among different safe communities. It is mentioned in literature that limitations in documentation of safe community activities, impedes the clear judgment about the effectiveness of the safe community model [19].

Conclusion
Safe communities throughout the world have shown to be successful but need more focus put on sustainability and improvement of relevant activities. Moreover, vast inconsistency in reporting the activities, approaches and methods in communities for safety promotion seemed as a barrier to have a standard efficacy evaluation of the safe communities.

Limitations
This study was done using the information available in the webpages of the designated safe communities published in WHO collaborating center for community safety promotion website in Karoliska Institute.

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