3. New Paradigms and Models for Evaluating Community Safety

Many of our policy ideas, models and pardigms regarding community safety in South Africa were influneced by or arose from certain international models and paradigms. These range from punitive and law enforcement approaches to crime prevention approaches to community safety ideas to the public health paradigm (building healthy communities). One paradigm does not necessarily negate the others and these different approaches might be taking place simultaenously in the same place. Nonetheless, it will be argued that there has been a gradual shift in terms of paradigms and models internationally and nationally from merely preventing crime (a negation) to promoting health and safety (pro-social outcomes across a wide range of indicators affecting safety). This development and its significance for indicator development will be explained in three sections as follows:

- International and National Paradigms
- A practical example of the paradigm shift: Moreland Australia
- International lessons for designing indicators

3.1 INTERNATIONAL AND NATIONAL PARADIGMS

The three most common paradigms for promoting safety--crime prevention, community safety and public health—are discussed below and this leads into a further discussion of the latest international standards for a safe community.

Crime Prevention

Throughout the 1990s there was much recognition that the traditional law enforcement approach was not working effectively on its own and there was a need for preventative approaches.[1] For instance, crime statistics and victim surveys could show that a criminal justice system based on retribution would not be able to stop crime (in many places it was spiralling upwards despite increased budgets for police and prisons). Crime could also be viewed as preventable. Several international colloquiums on crime prevention took place and UN resolutions were passed that included the influence of South Africans who had already formalised their own National Crime Prevention Strategy in 1996.[2] This led ultimately to the UN Guidelines on the Prevention Crime in 2002 which were intended to guide member states on this approach.[3]

Crime prevention was a 'ground-breaking' new development in global terms since it offered a paradigm with four significant advances over a law enforcement approach. Firstly, it viewed crime as preventable—a proactive rather than a reactive approach. Secondly, it focused on creating a better social order rather than just focusing on removing the disorder.[4] Thirdly, the new model emphasised cost-saving since 'prevention is better than cure.' Why treat victims and deal with perpetrators when it is cheaper and healthier to prevent it

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[1] Lab, Steven P (1992) Crime Prevention: Approaches, Practices and Evaluations, Cincinatti: Anderson Publishing Company; United Kingdom (1998) Crime and Disorder Act, http://www.opsi.gov.uk/acts/acts1998/ukpga_19980037_en_1

[2] National Crime Prevention Strategy (May 1996) Pretoria

[3] United Nations (2002) http://www.crime-prevention-intl.org/filebin/Generating%20Links%20for%20Website/UN%20Guidelines%20on%20Crime%20Prevention/United_Nations_Guidelines_for_the_Prevention_of_Crime.pdf

[4] Singh, Anna-Marie (1997) "Changing the Soul of the Nation: South Africa's National Crime Prevention Strategy,' The British Criminology Conference 15-19 July 1997, Selected Proceedings, Volume 2, Belfast; United Kingdom (1998) Crime and Disorder Act, http://www.opsi.gov.uk/acts/acts1998/ukpga_19980037_en_1

in the first place? Fourthly, the new model promoted multidisciplinary cooperation as the key to fighting the problem across a wider range of issues and for this reason it might have long-term impact.

Crime prevention also converged with a theory that appears to have emerged in 1979 especially regard to domestic violence but with eventual application to preventing all types of crimes.[5] The idea was that there were cycles of violence. For instance, a poor education produces young person not skilled enough to compete for employment in a capitalisitc marketplace and some of these might turn to a life of crime for survival. Likewise, a poor health care system might mean that some single mothers with HIV/AIDS cannot raise their youth properly and then the youth become involved in gangs--surrogate family associations. This idea that there are many such cycles of violence remains a widely accepted paradigm and much attention here and abroad focuses on integrated forums that include all the kinds of stakeholders that can break into the the many different kinds of cycles. This led to crime prevention partnerships and forums consisting of people both within and utsdie the criminal justice system such as social sevices, health, schools, housing, muncipalities, education, environmental services, civil society and a huge network of local stakeholders that could meet, strategise and commit resources to a monitored safety plan.

A very influential report on crime prevention evaluation also suggested that safety not only includes freedom from physical or emotional harm but also freedom from the threat or fear of harm or danger.[6] This quintessential idea also remains a valid focused and is also a common feature of the crime prevention model although it can be found within all the paradigms under discussion.

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[5] Walker, Lenore (1979) http://ezinearticles.com/?Lenore-Walkers-Cycle-of-Violence&id=1366375

[6] Sherman et al 1997

Another essential component to crime prevention theory was that both long term and short term measures are required. The long term efforts are the most significant: prevent criminality from ever arising (good schooling, youth programmes, healthy parenting, prenatal care etc). There is a also a need for more immediate measures to both (1) reduce the short-term risk that crime would occur (e.g., target hardening by fencing a school); and (2) to build and maintain confidence in the forums and strategies.

The development of crime prevention also had a particular influence on evaluations and indicators. Owing to the breadth of the approach, indicators cannot become defined too narrowly and yet in defining them broadly the evaluation methodology becomes extensive rather than intensive. The long term goals of crime prevention were also a challenge: results are not immediately measureable and sometimes not measured at all because longitiudinal studies are expensive, disciplined (no chopping and changing of strategy) and require significant planning.[7] Indicator tools owned by stakeholders or perhaps a municipality provide one way of overcoming this challenge—since measures can be routinely collected over a long period of time and owned by those driving the programme.

Crime prevention as defined in the UN resolution itself and perhaps more generally was flawed in one manner. As alluded to above, it excluded law enforcement approach in theory while in actual practice it was often admitted that good law enforcement was integral to crime prevention impacts. In other words, crime prevention and policing are not mutually exclusive but integral to each other: good problem-oriented policing will include an understanding of the causes of crime and its prevention. That crime prevention was

[7] Pelser, Eric (2002) Crime Prevention Partnerships: Lessons from Practice, Institute for Security Studies

basically addressing a perceived failure in the law enforcement approach accounts for the initial (historic) distancing between these two aspects.

There were also two other critical challenges to crime prevention theory as it evolved on the ground. The first was that inter-departmental and interagency cooperation to develop integrated plans and budgets were often difficult to create and sustain. Despite all good arguments and intentions, the term 'crime prevention' is often narrowly interpreted such that not all departments come to meetings or sustain their presence in forums. The phrase is more inviting to departments directly concerned with crime and many forums struggled to get involvement from certain departments like social services and health. Secondly (and more importantly), the crime prevention paradigm was based on negating crime rather than developing a pro-social vision of health toward which people could be united and progress measured. This often concentrated measurement on where a community had been in terms of crime levels but not necessarily where that community is now or where it wants to go. In other words, crime prevention focuses on the absence or reduction of crime, which is clearly not the only indicator of health and safety.

Community Safety

According to criminologist Peter Squires the discourse of community safety arose in 1986 and by the 1990s budgeted departments of Community Safety involving community safety professionals emerged at municipal or metropolitan level in many parts of the world during the 1990s (including South Africa) as a *sustained* way to facilitate strategic community partnerships around a range of safety issues and ensure that the resources for safety planning and delivery were allocated.[8] While crime prevention was a widely used term among academics and civil society members, it came to be reinterpreted as the promotion of 'community safety' within many

[8] Squires, Peter (1999) "Criminology and the Community Safety Paradigm: Safety, Power and Success and the Limits of the Local," British Criminology Conferences Selected Proceedings, http://www.britsoccrim.org/volume2/012.pdf

government circles—it set a more positive agenda, emphasised people and stressed that many community resources other than just police were involved. It had two strategic contributions if not advantages: (1) the possiblility of invoking wider social and economic planning; and (2) the capacity to create strategic partnerships for certain elements in a safety plan rather than insisting on forums which can sometimes be clumsy.

This new phrasing of the problem also had impact on civil society organisations. For instance, from 2000 the International Centre for the Prevention of Crime began to employ and defend the term community safety as a more holistic and positive way of conceptualising solutions.[9] From 1996, the UN also developed its Safer Cities programme (revised in 2006) which also seeks an integrated and holistic approach to urban safety issues and this had influence: many municipalities throughout the world developed departments of community safety.

Oddly enough, the paradigm of *community* safety is mainly criticicised on the grounds that it is not *community owned* since problems are often selectively constructed by policy makers and not always based on the expressed needs of communities.[10] In other words, community is defined more in terms of the bureaucratic dilineations and definitions (e.g., the administrative boundaries/divisions of a metropolitan area) rather than in terms of self-ascribed community concerns and identities. This helps with budgeting, policy-making and organising government resources but the selective problem construction can lead to problems of accountability—whose interests are being represented in the delivery of safety? Accountability often ends up with policy managers and in policy making systems rather than flowing from the community itself. Hence, while these departments can play a clear role in terms of building strategic partnerships the new trend is for communities to define themselves and to identify their own positive and pro-social indicators of health and safety as explained further below.

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[9] Shaw, Margaret (2000) The Role of Local Government in Community Safety, Montreal: International Centre for the Prevention of Crime.

[10] Squires, Peter (1999) "Criminology and the Community Safety Paradigm: Safety, Power and Success and the Limits of the Local," British Criminology Conferences Selected Proceedings, http://www.britsoccrim.org/volume2/012.pdf

The public health paradigm

This paradigm that developed as early as 1989 amongst public health sciences departments and organisations around the globe has much value in terms of indicator development. In fact, based on recent UN developments it seems that this is the paradigm driving the development of monitoring tools around the world amongst professionals and lay people concerned with health, safety and crime prevention. For instance, in Britain or Australia, community safety was from an early stage often and widely seen as a subset of health or social capital.[11] In this paradigm, one must ask what is a 'healthy community' and much of this is answered in terms of the community itself.[12] This approach creates a synergy between professionals and the community and in doing so embodies the health and safety indicators based on:

- A data driven system for monitoring and evaluation
- Positive and compelling discourse that attracts many departments and stakeholders not ordinarily part of the criminal justice system.
- Working with the community's own definitions, objectives and goals for health and safety (offering them ownership; not just opportunities for monitoring) while also bringing to bear professional guidance on what works or does not
- Clear incentives--the United Nation's World Health Organisation offers accreditation for those places that meet international standards as a healthy community (discussed further below)

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[11] Sherman, Lawrence W,, Denise Gottfredson, Doris MacKenzie, John Eck, Peter Reuter, and Shawn Bushway (1997) "Crime Prevention: what works, what doesn't and what is promising," University of Maryland: Department of Criminology, http://www.ncjrs.gov/works/

[12] Manifesto for Safe Communities. (1989) *Report from the First World Conference on Accident and Injury Prevention*. Karolinska Institutet, Sundbyberg; Svanström, L. (2000) *Building Safe Communities: a Safe CommunityMovement in the 2000s*. Proceedings of the 9th International Conferences on Safe Communities, Bangladesh, pp. 60–67.

While South Africa has practioners operating from all three paradigms descibed, some of this trend toward a public health paradigm (although not fully identified) was indicated with the recent work of Action for a Safe South Africa, a networking group, which in 2008 brought together about 400 expert South African delegates into eight different working groups to define safety. These groups were launched on the premise of a cycle of violence theory (as introduced further above) which basically shows that exposure to violence and abuse at all levels generates new cycles violence and that ways need to be found to intervene into each cycle. Nonetheless, the grouping of the thematic issues emerging from the conference were very much along the lines of promoting healthy behaviours rather than simply preventing crime (e.g. healthy mothers and resilient children; peace in the home, a sobre South Africa etc).[13] This suggests that a paradigm shift is already occurring among many of the country's top experts who concretised the key point that promoting healthy behaviour engages a wider range of activities (including but not exclusive to law enforcement and crime prevention) and can mobilise citizens more effectively than crime prevention alone.[14]

Meeting International Standards for a Safe Community

It is quite evident in the International Standards for a Safe Community (finalised in 2009) that much of the global community has shifted toward a more positive health promoting concept and since South Africa is part of this international community it should at minimum strive to meet these standards. In fact, these are more than just standards because meeting them leads to international certification as a safe community bringing economic benefits and rewards (e.g., investment, tourism). This also offers a very good standard for outcome indicators in the three targeted communities: the closeness or distance toward meeting international standards.

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[13] Lab, S. P. (2004) Crime Prevention: approaches, practices and evaluation, 5th ed, Bowling Green State University, Anderson Publishing; Holtmann, Barbara (2008) Breaking the Cylcle of Crime and Violence: Essential Steps to a Safe South Africa, Action for a Safe South Africa, Sandton: The Good News Pty

[14] Pennington, Steuart, ed. (2008) *Action for a Safe South Africa: What every South African can do to build a Safe Country,* Sandton: The Good News Pty Ltd.

The United Nation's World Health Organisation established a Collaborating Centre on Community Safety Promotion in 2002 which over a period of years has helped to bring together international public health bodies, cities, regions, civil society organisations and academics into conferences and networking opportunities with a big objective: decide on indicators for safe communities globally. These were refined from a starting point of more than a dozen indicators to only six (a few simple indicators are often more effective than many) and are highly influential both in literature and in establishing practice. In fact, to belong to the network of safe communities internationally, communities must apply and provide clear and documented evidence that they meet each of these six indicators:

1. An infrastructure based on partnership and collaborations, governed by a cross-sectional group that is responsible for safety in their community
2. Long-term sustainable programmes covering both genders and all ages, environments and situations
3. Programs that target high-risk groups and environments, and programs that promote safety for vulnerable groups
4. Programs that document the frequency and causes of injuries
5. Evaluation measures to assess their programs, processes and the effects of change
6. Ongoing participation in national and international safe community networks[15]

To reach the sixth indicator requires certification—an International Network of Safe Communities has been developed that actually certifies communities as being safe upon submission of required documentation concerning the described indicators (see Appendix A). Very few South African communities would be ready for application or certification owing to the rigorous standards that include the submission of both process

[15]Ekman, Diana Dr; Svanstrom, Leif Dr, (13 November 2008) Guidelines for Applicants to the International Network of Safe Communities, Who Collaborating Centre on Community Safety Promotion, Krolinska Institute, Stockholm, Sweden

and outcome evaluations (item five). However, the University of South Africa's Institute for Social and Health Sciences and South Africa's Centre for Peace Action can certify.[16] Internationally only 130 communities had been certified as safe as of end 2008 but the effort to reach these standards by communities around the globe constutitues a huge movement.[17]

The first UN indicator required to meet the international standards for certification as a safe community is establishing a reference group of a certain standard. It must involve representation from 12 specific kinds community, government and non-government groupings constituted in a way that follow these UN *guidelines* (cases can be made for similar forms of representation):

- Head of local government (the mayor's office)
- The government organisation responsible for public safety (e.g., SAPS, Department of Community Safety)
- The local health care system where injuries are addressed
- Emergency response services
- Traffic Safety
- Private sector partners
- Sports and Recreation
- Education
- Senior Citizen Groups
- Red Cross or Equivalent
- Community-based injury prevention partners

[16] WHO collaborating Centre on Community Safety Promotion (2009) http://www.phs.ki.se/csp/pdf/poster/SafeComm_poster_070605.pdf

[17] BMC Health Services Research (2009) 'What Promotes Sustainability in Safe Community Programmes?' http://www.biomedcentral.com/1472-6963/9/4

- Service Clubs[18]

For the second indicator, there must be task force groups doing the actual work in the community covering safety in traffic, homes, work, sports, schools, public places, *and* for children, the elderly, crime and violence prevention, suicide prevention and injury surveillance. Full descriptions of the members on this 'community safety' grouping must be submitted for certification.

The third, fourth and fifth indicators require full-time professional groups (usually at municipal level) that work on implementing long term sustainable safety programmes, injury surveillance and evaluations. In this paradigm, preventing crime is a subset of preventing injury and data on the frequency and causes of injuries is usually covered by surveys (e.g., this is done in South Africa in terms of the injury surveillance work of the Medical Research Council). Ultimately expert evaluations and studies are required to measure the progress of programmes and not one but several evaluation reports are submitted for certification as a safe community (about 130 communities have been certified at this writing). Furthermore, final certification will bring a UN team to the site to meet the reference group![19] This trend of identifying sites of internationally designated safe communities will probably continue for the remainder of the century and the standards are very high but the six UN indicators (listed further above) can provide some direction to indicators for SA communities--our local indicators should fit this *aspiration* of international certification.

A Safe Communities Canada group has designed four 'readiness' indicators showing the preparation and commitment toward reaching the international standards that can inform South African indicators (1) leadership comprised of specified types of community organisations and

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[18]Ekman, Diana Dr; Svanstrom, Leif Dr, (13 November 2008) Guidelines for Applicants to the International Network of Safe Communities, Who Collaborating Centre on Community Safety Promotion, Krolinska Institute, Stockholm, Sweden

[19] Ekman, Diana Dr; Svanstrom, Leif Dr, (13 November 2008) Guidelines for Applicants to the International Network of Safe Communities, Who Collaborating Centre on Community Safety Promotion, Krolinska Institute, Stockholm, Sweden

individuals that focus on injury prevention and safety promotion; (2) priority setting progrmmes based on systematric processes and methodologies like studies and evalautions; (3) sustainabile operating budget with admininstrative capacity and (4) community engagement.[20] This will be included in the proposed monitoring tool for South African communities as key indicators along the route toward meeting global standards. For instance, the kinds of initial safety oversight committee required is not quite as stringent as the UN Standard but travels toward it. In Canada, they developed a scorecard system so that active participants in safety could meaure progress on a 'report card' of around 50 questions such as representation on the Safe Community Leadership Group (i.e., the community safety forum). Perhaps municipal government, health, fire and police are represented but not provincial government or business and this results in a certain score.[21]

Not all cities in Canada are obligated to follow the route of the Safe Communities Canada group and Calagary takes the six UN crtieria for safe community designation as its direct departure point.[22] They met all the WHO criteria for designation as a safe city as outlined and they had a head start since 'Safe Calagary' had existed since 1999 and already networked hundreds of organisations with a focus on injury prevention, violence prevention and the natural and built environment. The two lead groups were the Calagary Injury Prevention Coalition and the Action Committee Against Violence (organisations with 20 years of experience) that could be brought together to help meet the UN mandate for a safe city. Of relevance is that they only have four catergories of safety indicators to measure the progress of their crime prevention programmes:

- Public attitude, beliefs and behaviours measured by a safety survey
- Injury prevention data mainly measured in terms of hospital statistics: hospitalisation, fatalities, emergency room visits per capita

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[20] Safe Communities Canada (2007), http://www.safecommunities.ca/documents.php?category=Resource%20Documents

[21] Safe Communities Canada (2007), http://www.safecommunities.ca/documents.php?category=Resource%20Documents

[22] Safer Calgary (2009) Safe Communiy Designations, http://www.safercalagary.com/safecommunity.htm

- Crime and violence data according to police statistics on personal injury, property, youth crimes, domestic violence, hate crime, child interventions and substance abuse
- Environmental measures on air, water and soil quality[23]

A task group was established to coordinate the measurement of these indicators and the stakeholders include health experts, police, the municipality, the University of Calgary.[24]

3.2 PRACTICAL EXAMPLES: DESIGNING INDICATORS

What should community indicators look like? Involved community members develop their own objectives and goals for community health (which can be quite wide-ranging) and then these can be tested against national and international indicators that can be used to measure the progress being made or achieved toward meeting the goal of safety. Expetise helps the community to decide "Where do we stand *and* where are we going in terms of our objectives and goals for safety?" It is from this new paradigm that a tool is being constructed and therefore much of the focus of discussion is in terms of how this affects and explains the work.

Indicators should be simple (easy to understand), policy relevant, available, measurable and replicable.[25] Simplicity is required because good indicators are ones that everyone understands (there are a large number of participants including community members and partners). Community indicators for safety must fit with policies and strategies at national, provincial, and municipal levels but must be distinguished too

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[23] This last one is not being done in South African communities and the results would probably shock many of us because many of our informal communities are located in areas that were not studied in terms of environmental hazards such as powerlines.

[24] Safer Calgary (2009) Safe Communiy Designations, http://www.safercalagary.com/safecommunity.htm

[25] Whitzman, Carolyn and Mayes, David, 'Community Safety Indicators: what works, what doesn't, what is promising,' http://www.griffith.edu.au/__data/assets/pdf_file/0017/81251/city-governance-05-whitzman.pdf

owing to scale and the distinctive activities and opportunities that exist at the local site. Indicators that are neither available nor measurable are not useful—the key idea is that they must provide easily accessible information on progress toward community safety objectives. They must be replicable—employable across time and space (otherwise we cannot compare and measure progress).

Two brief examples might help followed by a more detailed one. Northwest Indiana (a farming area in the US considered a 'regional community') used aggregate statistics from the Child Protection Services to indicate a safer community for children owing to declines in cases (both aggregate and percentage figures) of child neglect, child physical abuse and child sexual abuse between 2000 and 2006 by around 30%.[26] These indicators were simple, policy relevant, available, measurable, and replicable. Another experience in developing community safety indicators in Cambridge, United Kingdom validates these findings—there are only seven indicators for safety in an indicator tool that looks at a large range of health and well-being issues.[27] The indicators were few, measurable and much is drawn from easily-available police statistics (e.g., domestic burglary per 1000 households; violent crime per 1000 population). It is likely that on crime prevention there should not be much more than 20-30 clear indicators in total which can be analysed together to measure progress. Otherwise, the effort will become too cumbersome to enrol.

[26] Northwest Indiana Quality of Life Council (12 May 2009), "A Safe Community," http://www.nwiqlc.org/wiki/a-safe-community

[27] Cambridge City Council (2007) http://www.cambridge.gov.uk/ccm/content/strategy-and-partnerships/bvpp/community-safety-performance-indicators.en

Learning from Moreland Australia

A method for developing indicators was established in Moreland, Australia (near Melbourne) with the outcome being a monitoring system for the entire state of Victoria involving all communities but it started out and is often still known by its original title 'the Moreland Wellbeing Report'. It is updated annually and published on a website.[28] The history starting with the first-cut indicators for Moreland and how these were inadequate and led to the ones issued today as the Wellbeing Report is full of lessons about appropriate indicators. It also reveals a lesson for process: the first cut indicators always need to be refined and these evolve best and most appropriately in a consultative process between the community and professionals over a period of a few years.

Priority Issues (and four key objectives)

The initial priority in the case of Moreland, Australia was to integrate partnerships between the community and local planners by deciding on an agreed set of indicators for monitoring and evaluating. The focus was not on safety per se but on health and well-being—safety was a subset of this—and this element persists and fits with the UN approach described above. There were four initial objectives:

- Utilise the Environment for Health Framework and the Moreland Municipal Public Health Plan to guide indicator development (the framework)
- Develop an integrated and sustainable approach to the monitoring and evaluation of health and well being planning an action by the council
- Improve the opportunities for community engagement in the process of monitoring progress in community health and well being

[28] Moreland Wellbeing Report (2008), http://www.communityindicators.net.au/wellbeing_reports/moreland

- Provide easily accessible information about health and wellbeing in Moreland for stakeholders (mainly through the council's webpage)[29]

More important than these specific issues, is the idea that objectives (or goals) are required to provide sense and guidance to indicator development. Furthermore, some of these objectives were pre-set in terms of strategic frameworks at municipal level—these public health indicators were part of an integrated plan—an overall municipal strategy for development. This suggests a lesson too: locating the municipal plans is very important and in the case of South Africa, integrating health, safety and crime prevention into the Integrated Development Plan must be seen as a key outcome.

Stakeholders

The initial stakeholders were mainly municipal workers and very few community stakeholders. This included:

- All council departments
- A Moreland Health Safety and Wellbeing Leadership Group (senior representatives from key government departments)
- Local councillors
- Community members

Australia is a much decentralised country not only composed of federal states but of cities with much autonomy to structure their own departments (e.g., the organisation and structure of police departments can vary from city to city). The municipality and its council largely owned the indicator tool and community members were not well consulted in the initial stages as will be discussed below. Eventually, the entire

[29]Spargo, Katherine and Stubbings, Kerry, Health Planning for Sustainable Progress, PowerPoint Presentation, Moreland City Council, 16 October 2003

province came aboard. In the initial stages, a change in elected officials over the course of developing the tool was also revealing—one regime was regarded as more consultative than another by analysts and managers. Nonetheless, a council working group was established to engage in a literature review (similar to this one) and to develop a framework and establish indicators. The draft indicators were first workshopped internally and then eventually with the councillors.

Specificity of the indicator

First, the focus was broad and this had an impact on the 'first cut' tool. It included 14 key elements based on the determinants of health:

- Social and economic circumstances
- Employment
- Education
- Housing
- Built and natural environment
- Early years—birth to adolescence
- Personal well-being and safety
- Access and availability of services
- Social inclusion and social support
- Social Participation
- Recreation, arts and leisure
- Transport
- Information

The framework for the indicators (14 categories) was too big because each one established an area for constructing a score of community health indicators—thus volumes were generated. Too many indicators were the result and they were so complex and difficult to measure that the first-cut was not so successful.

There was one great value in the initial indicators: the public health model seemed to encapsulate personal well-being and safety in a way directed toward positive goals that people could relate to and therefore were willing to participate. This framing in terms of a positive vision of health can help with safety indicators—the community can work together toward this while crime prevention is fully implied. For example, the category Early Years Birth to Adolescence is described by one goal: "safe births, healthy and happy early years with minimum stress on family and home life." Creating a healthy, happy, and stress-free home means less domestic violence and safety and policing are fully implied as part of a *proactive* vision of public health.

Once these health and wellbeing objectives are understood then measuring progress toward them requires indicators. For instance, for employment (an indicator of both public health and safety) the key indicators were these:

- Low unemployment rate (measured by percentage of labour force employed)
- Labour market participation rate (percentage of population over 16 years of age in the labour force)
- Local Employment (based on census information)

Part of community health is employment which creates a prosperous local economy and less stress on the individual (preventing crime). One could add that a quality education leads to fewer school drop-outs and higher levels of employment and this helps to create safety. Examples can go on and on but a public health framework seems to be a valid and effective way to work positively with communities and generate positive support for safety initiatives.

There is a specific flow to the indicators—(1) a vision of a healthy community; (2) a description of this vision according to key categories; (3) an objective for each category; and (4) indicators to measure each objective. Community health is the vision in Moreland and initially there were 14 ways to describe this each with its own objective with measurable indicators attached. For instance, the category 'Built and Natural environment included this goal: a 'sustainable, viable, *safe* and liveable city where shoppers can shop, work and socialise locally and that promises physical activity and social connection."[30] There were two main indicators for this in the initial Moreland Plan: (1) level of community use and satisfaction with natural open space; and (2) the number of complaints about the quality of the built and natural environment.

A framework paper accompanied the first cut indicators to explain the selection process and the criteria for each set of indicators for each of the 14 elements. This broad framework was utilised to develop an indicator template tool which contained the 'first cut' of the Moreland Health and Well-Being Indicators that would then be workshopped with the community.

Challenges

This approach described above resulted in a huge document (initially) that challenged Moreland in several ways. It was difficult to negotiate with communities on such a big document and difficult to monitor. This was complicated by significant changes in council members during the time of strategic planning, which altered timelines and priorities (the planning agenda) such that the first cut at the indicators took five months longer than anticipated. Most importantly, consultation was also very limited with much of the initial work being done NOT at community level but at council level.

[30] Spargo, Katherine and Stubbings, Kerry, Health Planning for Sustainable Progress, PowerPoint Presentation, Moreland City Council, 16 October 2003

One of the biggest challenges with the first cut indicators was the lack of a plan for monitoring and evaluation. It is easy to develop a large set of indicators that describe safety in the broadest terms but this then creates a massive amount of data (not to mention original research efforts). Who will analyse it? Initially, there was little planning around the collection and analysis of this data resulting in the conclusion that Moreland needed to be 'smarter' about indicators.[31]

Lessons from Moreland, Victoria for designing indicators in South Africa

The initial experience in developing the Moreland indicators led to some clearly identified lessons that might be valuable in the context of South African communities:

- Ownership of the indicators needs to be decided at an early stage
- Community consultations are critical because it is easy to design indicators that have no relevance to community members or are otherwise too complex for them to embrace
- Monitoring and evaluation must be considered at the outset—how many indicators can be evaluated? (e.g., initially there was a huge set of indicators in Morelandand but no one or department had the time and opportunity to analyse such extensive data)
- A webpage was desired for consultation but was not in the initial plan creating long delays in its actual employment although eventually this was the key to success[32]

More importantly, what changed when it came to designing the set of indicators being used now as opposed to the first-cut indicators? The answer:

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[31]Spargo, Katherine and Stubbings, Kerry, Health Planning for Sustainable Progress, PowerPoint Presentation, Moreland City Council, 16 October 2003

[32]Spargo, Katherine and Stubbings, Kerry, Health Planning for Sustainable Progress, PowerPoint Presentation, Moreland City Council, 16 October 2003

- The indicators were fewer
- The indicators were much simpler
- Measurements became more basic so as to rely on two types of sources: (1) a simple survey (that covered more than half the indicators); and (2) existing statistics (e.g., specific measures *easily* available from various departments like the overall crime rate from the Victoria police).

The original indicators were impossible to monitor effectively because these demanded much *original research* for each indicator setting up a massive undertaking, Just one activity for one indicator could be a major task (e.g., consult every hospital and track down all health records of a community for comparative analysis). Eventually, simpler indicators that drew on either survey data or easily available statistics had to be utilised.

Today the ratio of research to indicators is reversed: one survey covers 10 out of 18 indicators (56% of them) and there are another six sources of data covering the remainder and this draws on pre-existing surveys and data bases (e.g., census materials, aggregate police statistics, and computer accessibile documentation) are utilised. Interestingly, the community essentially reports on its own health, safety or well-being in most instances. The lesson is clear: easily administered surveys for self-reporting *and* easily available indicators are important. Below are the 18 indicators currently in use and a brief statement about them (they are now published on a website):

1. SELF-REPORTED HEALTH— The *Victoria Community Indicator Survey* respondents to measure their own health (e.g., 48.9% in 2007 said excellent or very good)
2. SUBJECTIVE WELL-BEING-- The *Victoria Community Indicator Survey* asks respondents to rate satisfaction with their own lives

3. CHILD HEALTH ASSESSMENTS—This data is collected from Maternal and Child Health Services and analysed by the Department of Education and Early Child Development)

4. PERCEPTIONS OF SAFETY: The *Victoria Community Indicator Survey* respondents say how safe they feel walking at night in the community and how safe they feel walking in the day in the community.

5. CRIME STATISTICS: This data is collected from the Victoria Police--offences per 100,000 people are compared year after year

6. LIFE-LONG LEARNING: Home internet access and usage is measured as the indicator

7. ECONOMIC ACTIVITY: The national census is used to rate skills levels of the population

8. INCOME: The Australian Bureau of Statistics provides these (gross weekly household income)

9. FOOD SECURITY: The *Victoria Community Indicator Survey* asks respondents if they ever ran out of food in the last 12 months

10. EDUCATIONAL QUALIFICATIONS: Percentage of people with tertiary qualifications is taken from the census figures

11. ADEQUATE WORK-LIFE BALANCE: The *Victoria Community Indicator Survey* asks whether or not work and family life interfere with each other.

12. HOUSING AFFORDABILITY: The Census is utilised and shows percentage of households spending 30% of more of their gross household income on rent or mortgage payments

13. TRANSPORT LIMITATIONS: *The Victoria Community Indicator Survey* asks respondents if their day to day travel has been restricted in the previous 12 months

14. WASTEWATER RECYCLING: The *Victoria Community Indicators Survey* asks respondents if they engage in any water-saving measures given on a list

15. HOUSEHOLD WASTE RECYCLING: An annual survey conducted by Sustainability Victoria is utilised that looks at local government services

16. PARTICIPATION IN ARTS AND CULTURAL ACTIVITIES: The *Victoria Community Indicators Survey* is utilised to check on the range of such activities members participated in during *the last month*

17. COMMUNITY ACCEPTANCE OF DIVERSE CULTURES: *The Victoria Community Indicator Survey* asks respondents, "Do you agree that it is a good thing that a society be made up of diverse cultures?"

18. CITIZEN ENGAGEMENT: *The Victoria Community Indicator Survey* asks respondents if they attended a town meeting or public hearing in the last 12 months

Not all these indicators are relevant to South Africa and there are too many for starting out on a new programme more focused on crime prevention (owing to its severity) but the bottom line on the story of the Community Wellbeing Indicators is that they came to be simple, policy relevant, measurable and replicable. Half of it rested on one easy-to-manage survey with good indicators and the other half on the collection of easily available documentation from websites, police, government departments and organisations. Thus, the combinations of easily available statistics and simple surveys told the story. The survey had to be simple and revealing: Would you walk in your neighbourhood during the day? Would you do the same at night? There were very few questions for a single indicator—usually just one or two. These provided indicators that were not overly detailed but powerful.

The Moreland Report was such a big success that it evolved into the Victoria State report covering scores of communities and there are measures to compare all areas of the state to see where progress has been made and where the state needs to focus. This standardisation in measurement allows the state to compare the status of different communities on health and safety issues. The indicator tool is not static either and new indicators do arise. Thus, the tool has to be seen as something organic and interactive—it evolves continuously as communities, needs, priorities and available information change. It is both website based access and the community interaction owing to it that allow for much of this organic

development. Ownership ultimately came to be shared between municipal official, Victoria State officials and active citizens who accessed the site and participated in surveys.

3.3 INTERNATIONAL LESSONS FOR DESIGNING INDICATORS AND EVALUATING SAFETY

Given the above findings, it is evident that both expertise and local knowledge are required in constructing a set of indicators that can achieve standards established for a safe community. It is a collective process that must bring together experts (e.g., government officials, planning bodies) and the affected community. Expert research is involved for the purpose of:

- Providing a framework for the selection of indicators (e.g., one must research existing policy and plans)
- Locating good practices (i.e., no need to 'reinvent the wheel')
- Enabling an analysis of existing or proposed indicators for their utility (i.e., there is literature on what works and what does not in terms of indicators)
- Providing evaluations (or testing the tool in the early stages)

Ultimately community safety indicators must be endorsed by communities and be practical for those that will apply and utilize them such that the findings of experts must be aligned to the reality on the ground including local perceptions. The indicators must be relevant and accessible to community members and therefore they must play a key role in defining community safety too. Thus, developing an indicator tool must be a consultative process between experts and community representatives and such a process is not quick—it will consume a few years (e.g., Calgary began in 1999 and is now meeting UN standards). The methodology, while organic and flexible, might follow a route similar to this:

- Use research to define the broad-state determinants of health, well-being and safety (what are the goals of safety?)

- Compare these to the community's existing safety plans to make sure that their concerns are being covered
- Select and establish indicators and the criteria for each of those determinants
- Develop an indicator tool
- Evaluate the existing safety plans using first cut indicators
- Discuss this with the community (workshops)
- Redraft the tool

These are some other lessons about designing indicators from the cited material that can be incorporated into the process of developing indicators for South Africa:

1. Utilise both the literature and the community's health and safety objectives (consult *their* plans and planning bodies) because *community* safety indicators are designed around these in a process that includes both professionals and community members

2. Do not construct more than a few easily measurable indicators for each safety objective (only one or two questions to start per topic for perhaps 20 indicators)

3. Make sure each indicator is simple (easy to understand), policy relevant, available, measurable and can report on at least one basic objective of the safety plan in a replicable (dependable) way

4. Make sure the indicator is easy to collect, measure and record-- original research for every indicator is impossible and diverts energy away from the project's purpose of helping the community meets its objectives in a timely way (therefore available stats are very important)

5. Devise a simple survey to citizens or perhaps representative bodies engaged in crime prevention (e.g., neighbourhood watch members) and through self-reporting by informed community members one can measure many key indicators fairly easily

In terms of what gets measured, the indicators of the WHO Collaborating Centre on Community Safety Promotion and the Community Action Plan of the Safe Communities Canada are worth consulting (the second one helps show how to operationalise the first). Taken together, these might be some critical indicators:

- A leaderships table demonstrates that there is a cross-sectional partnership body (like a community safety forum) comprised of specified community organisations and specified indivuduals who can focus on community safety and provide oversight
- The community is engaged and informed based on a thoughtful and comprehensive plan (communications)
- Professional people are engaged on permanent basis in long term safety programmes
- Key and critical segments of society are being targeted--especially high risk groups and environments
- Specific programmes on injury prevention and safety promotion are developed and prioritised based on systematic processes and methodologies
- An operating budget demonstrates sustainability and adminitrative capacity
- The work is being monitored and evaluated regularly and professionally[33]

This experence of working methodically and professionally toward developing and indicator tool should help provide communities with a measureable and sound ways of solving their safety problems. Succinctly put, there is a saying, "what gets measured, gets done."[34] Therefore indicators also play a big role in the development of safety by presenting a vision of how to achieve it in a way that is measurable. Eventually it

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[33] This was developed from two sources: Safe Communities Canada (28 February 2007) Community Action Plan: 10 steps to designation; Ekman, Diana Dr; Svanstrom, Leif Dr, (13 November 2008) Guidelines for Applicants to the International Network of Safe Communities, Who Collaborating Centre on Community Safety Promotion, Krolinska Institute, Stockholm, Sweden

[34] Community Services Planning Council (1998) Community Indicators: Measuring Our Progress Toward Healthy Communities, Sacramento, CA USA

should lead to South African cities engaging in international diaglogue on safe communities that might further empower those engaged in the work. Certainly every city should seek to achieve UN status as a safe city and while this draws on many paradigms it includes broad public health measures that the tool must account for. In doing so, the tool must be clever and not so large or abstract that it cannot be easily utilised by people from both the municipalities and localities to measure progress on their plans.