

**Developing the evidence-base for safe communities: A multi level, partly
randomised, controlled trial**

M. Seedat^{1, 2}, R. McClure^{1, 3}, S. Suffla^{1, 2}, A. van Niekerk^{1, 2}

¹Institute for Social & Health Sciences, University of South Africa, Johannesburg, South Africa; ²Medical Research Council-University of South Africa Safety & Peace Promotion Research Unit, Cape Town, South Africa; ³Injury Research Institute, Monash University, Melbourne, Australia

Corresponding Author:

Professor Mohamed Seedat

PO Box 1087

Lenasia

1820

South Africa

Email: Seedama@unisa.ac.za

Phone: +27 (011) 857 1142

Biographical Notes on Contributors:

Prof Mohamed Seedat is the Director of the University of South Africa's Institute for Social & Health Sciences and the UNISA-MRC Safety & Peace Promotion Research Unit. Prof. Seedat works in the areas of public health and community liberation psychology. His research interests include violence and injury prevention, safety and peace promotion, the politics of making community and knowledge production, as well as the role of spirituality and religion in human development.

Prof. Rod McClure is Director of the Injury Research Institute, Monash University, Australia. He has medical qualifications, extensive clinical experience in emergency medicine, a PhD in injury epidemiology and specialist training in public health medicine. Prof. McClure also holds the positions of Professor Extraordinarius, Institute for Social and Health Sciences, University of South Africa and Professor, Faculty of Medicine Nursing and Health Sciences, Monash University.

Ms. Shahnaaz Suffla is trained as a clinical psychologist, and is a senior scientist within the Medical Research Council-University of South Africa Safety and Peace Promotion Research Unit. Her research interests include issues related to gender, peace, and violence and injury prevention.

Prof. Ashley Van Niekerk is a programme manager at the UNISA-MRC Safety & Peace Promotion Research Unit. He has a background in clinical psychology and a PhD in social medicine. His research interests include childhood injury occurrence, particularly due to burns, and injury prevention in and around home settings. Prof. Van Niekerk holds the position of Professor Extraordinarius at the Institute for Social and Health Sciences, University of South Africa.

Abstract

Safe communities, representing a global activation of the public health logic, may be strengthened through theoretical, methodological and empirical support. In the spirit of this Special Issue that aims to analyse the achievements and challenges inherent to safe communities, we offer our contribution in the form of a methodology of a multi-country child safety, peace and health promotion study. The study, situated within an African-centred initiative called *Ukuphepha* -an isiZulu word meaning demonstrating African safety- is underpinned by four theoretical claims that frame injury and violence prevention as a multi-disciplinary issue to be addressed through a suite of interventions to family and extended social systems. The interventions, sensitive to the priorities of each participating country, have been informed by the literature on effective interventions and the authors' joint experiences of community development. The study is designed as a population-based, multi-level, multi-intervention partly randomised controlled trial, and there are potentially 16 participant communities representing South Africa, Mozambique, Egypt, Zambia, Uganda, Bangladesh, Malaysia and Australia – over three commencement phases. Whereas process evaluation will focus on community engagement, impact evaluation will consider risk and protective factors, and outcome evaluation will examine the overall effectiveness of the interventions. Notwithstanding the many challenges, the study will provide insights into the methodology and mechanisms of ecologically-oriented interventions that locate injury and violence preventions as an activity arising from safety, peace and health promotion.

Keywords: safe communities methodology; multi-level; multi-intervention; partly randomised controlled trial; Africa

Introduction

We use the principles entailed in the concepts of safety, peace and health to design and develop an Africa-centred child injury and violence prevention study, with a view to illustrating how such an initiative may advance the theoretical and scientific basis for the safe communities approach. The safe communities approach represents a specific global activation of the public health logic. It recognises the psychological, social, economic and criminological dimensions of violence and injuries and involves the promotion of ecological actions to address risk and protective factors at multiple levels (individual, school, peers, family, community and society) using interventions aimed at universal, selected and indicated groups. The approach embodies a multi-disciplinary and multi-sectorial engagement in the control of violence and injuries and promotes interventions across the full primary, secondary and tertiary prevention continuum.

The concept of safe communities that emerged in western Europe in the early 1980s and which resonates with other earlier community development and community psychology perspectives originating in the 1960s and 1970s in countries such as South Africa (see Seedat & Lazarus, 2011), gives substance to the public health logic by positioning multi-sectoriality, multi-disciplinarity, evidence, long-term investment, community participation, registration of injuries, documentation, evaluation and dissemination as the guiding principles of community-based prevention actions. The global safe communities network, which brings together more than 200 demonstration programmes located in different regions of the world, actualises these public health principles, ideals and overall approach.

Despite its inherent intentions, the safe communities movement is fraught with challenges. Among the challenges is the uneven operationalisation of safe communities across different regions of the world. Most of the safe communities programmes are located in well-resourced contexts of Europe and North America. In Africa and other resource challenged environments however, the absence of a critical mass of researchers, the lack of a community-based infrastructure, and competing public health priorities, hamper the uptake and translation of the vision and ideals of the safe community model.

Where safety promotion initiatives do exist in these environments, they tend to be informed by models that remain untested for their contextual and cultural fit, and relevance for local conditions. A recent Cochrane Review (Spinks, Turner, Nixon, & McClure, 2009) concluded that there was no consistent relationship between status as a WHO designated Safe Community and resultant changes in injury outcomes. Evaluations for 21 communities, collectively from Sweden, Austria, Norway, Australia and New Zealand, were included in the review. Spinks *et al.* (2009) argue that the science of community-centred injury prevention is compromised by the diversity and minimally demonstrated efficacy of safe community approaches and activities, the relative dearth of evaluations undertaken, methodological limitations in community-based evaluations, and the distinct variation in observed injury rates across identified communities. Similar findings were reported by Spinks and associates in an earlier systematic review of community-based childhood injury prevention programmes undertaken in 2004 (Spinks, Turner, McClure, & Nixon, 2004). Such systematic reviews, highlighting the under-developed theoretical, methodological and empirical

bases of safe communities, offer a compelling case for robust studies in the application of the safe community approach.

We argue that the safe communities approach depends on the foundational concepts of safety, peace and health. The aim of this paper is to articulate a methodology, based on these three foundational concepts that can be used to develop an evidence base to support the intentions and achievements of the safe communities movement, within the multi-disciplinary oriented, ecologically aligned public health logic. Within the context of this Special Issue that intends to offer a critical reading of the successes, challenges and gaps in the safe communities movement, we describe the methodology in terms of a multi-country child violence and injury prevention study located within an initiative called *Ukuphepha*. We begin with a brief description of *Ukuphepha* (an isiZulu word meaning *demonstrating* safety), and then outline the aims and scope of the child study itself.

Ukuphepha: Demonstrating African Safety, Peace and Health

Ukuphepha is an initiative that seeks to: implement, evaluate and maintain integrated safety, peace and health promotion programmes in resourced-challenged communities in participating African countries; regularly convene scholarly fora dedicated to generating critical African-centred safety and peace promotion theories and methodologies; and stimulate a network of service-based agencies. The initiative will establish sites of study of innovative interventions, and combine injury data collection with intervention applications and research-related community engagement. The initiative will focus primarily on multi-site safety, peace and health promotion interventions that are responsive to the emergent injury profiles of each participant

community. Emerging researchers and post-graduate students as well as community workers will be hosted at the initiative's sites for instruction and training on the theory, methodology and implementation of injury prevention and safety, peace and health promotion. The training and capacitation work is intended to develop scarce skills and expertise across the region, as well as create opportunities for longitudinal studies and ongoing collaboration between partners. The Africa-centred group of scholars is expected to act as a resource within the sector, contributing to the African and global science base and supporting safety, peace and health promotion initiatives in underserved communities in particular. The network of service-based agencies, which is emerging rapidly, will both draw on, as well as act as a resource to support the creation of safety promotion and the development of skills linked to technological improvement and innovation, and contextual relevance.

The Child Injury and Violence Prevention Study

Claims, Organizing Logic and Assumptions

This study is underpinned by four claims, which provide the organizing and theoretical framework for the study.

Injury and violence prevention is an activity arising from the integration of three streams: the promotion of safety, peace and health.

Safety, peace and health have historically been conceptualised as distinct areas of focus, informed by inimitable epistemological, ontological and methodological approaches, and accordingly observed to relate to injury and violence prevention in somewhat discrete and detached ways. However, conceptualisations of safety, peace and health

have shared dominant assumptions about the drivers of individual, community and societal well-being in that each:

- 1) is considered an essential individual, community and societal resource (e.g. World Health Organization, 1998);
- 2) is concerned with structural obstacles that function to obstruct individual and collective welfare (e.g. Christie, Wagner, & Winter, 2001; Galtung, 1996);
- 3) values the importance of catalysing change at the levels of beliefs, attitudes, values, knowledge, behaviours and structures within the local, national and international milieu (e.g. Arya, 2005); and
- 4) recognises the capacity of individuals, collectives and broader systems to increase control over the determinants of injury and violence (e.g. Stachtchenko & Jenicek, 1990).

The embedding of injury and violence prevention within such a multi-disciplinary and integrated frame resonates with critical perspectives on knowledge making and social praxis, which place the accent on: 1) the social determinants of violence and injury; 2) challenges to dominant discourses that support systemic exploitation, discrimination, oppression and inequity linked to injury and violence; 3) honouring of multiple voices and knowledges in processes of social change; 4) adopting an activist agenda in the pursuit of social justice; and 5) the sustainable satisfaction of basic human needs as essential for human development and well-being (e.g. Christie et al., 2001, Freire, 1970).

Effective promotion of safety, peace and health recognises and addresses multiple drivers at each of the ecological levels: societal, community, household and individual.

Safety, peace and health are the consequence of interconnected conditions and events (either risk or protective factors) (Susser & Susser, 1996). The promotion of safety, peace and health therefore relies on a comprehensive understanding of broad societal and community factors, as well as more localised factors at the household and individual level. Arguably, the targeting and application of interventions at each of these ecologic levels could result in a more sustained and successful population-based approach to injury prevention.

Communities are characterized by their distribution of both risk and protective characteristics.

Protective factors, also referred to as assets, and which may include a focus on sense of community, community cohesion, community resilience and other similar capacities directed towards transformation, may be mobilized to mediate the deleterious consequences of risks and promote safety, peace and health in the long-term. Within this context, social assets may be tangible (e.g. housing facilities), behavioural (e.g. crossing roads at pedestrian crossings), social (e.g. development of a community patrol) or structural (e.g. good community leadership and organisation). Research suggests that the fostering and supporting of strong, protected, socially cohesive communities, which prioritise social connections and community life, is an important strategy for increasing safety (e.g. Holdsworth & Hartman, 2009).

The promotion of safety, peace and health is partially contingent on democratic citizenship expressed through active community engagement in the design, implementation, monitoring and evaluation of promotive initiatives.

Citizenship (Bulbulia, Seedat, & Lekoba, 2011), enacted through participatory processes that focus on a shared ownership of the injury challenge and associated solutions, recognition and mobilisation of community assets, and collective responsibility for the identification of priorities and appropriate interventions, is considered as key for effective and sustainable injury prevention and safety, peace and health promotion (Klaasen, Morag MacKay, Moher, Walker, & Jones, 2000).

The Interventions

The claims and assumptions described in the previous section were used as the basis for developing the interventions and evaluation design of the child study. The *Ukuphepha* child study seeks to deliver a suite of interventions to family and extended social and living systems through home visitations, as well as through community-wide interventions, including early childhood development centres (ECDs) and outreach to play parks. Priorities for the *Ukuphepha* interventions have been determined by site-specific concerns and known causes of childhood mortality and morbidity in the selected communities. Both the characteristics of the study and the specific component interventions have been selected from those that have previously being demonstrated under research environments to be efficacious. The nature of the intervention delivery systems, (i.e. the nature of the study strategies and processes) has been developed from the literature on effective interventions and informed by the authors' collective experiences of community development.

The basic organizing structure of the study is illustrated by a three dimensional matrix (see Figure 1). One axis represents the risk/protective factor being addressed by the intervention, and the second axis depicts the nature of the factor being addressed by the

programme (in terms of it being an economic, social or physical factor). Specified on the third axis (i.e. the face of the cube) are the observational and implementation components of the study. Also indicated by the letters A-C and a-d is that there will be several discrete implementation types that will be randomly distributed across the intervention arms of the study.

[Figure 1 about here]

The two basic delivery mechanisms are Community Asset Management and Mobilisation (including an ECD Intervention), and a Home Visitation and Strengthening Intervention.

Community Asset Management and Mobilisation

The community level intervention includes several components: education and sensitization, outreach, advocacy and emergency services offered by responsive resource persons and community mobilization.

The *education and sensitization* component, embracing public health and community engagement principles, focuses on fostering community awareness and insights about the magnitude and prevalence of injuries, violence and ill-health as well as the drivers and determinants of safety, peace and health promotion. Assuming a competency and assets perspective, the community is alerted to the possibilities and scope for promotive and community participatory actions.

In the *outreach* component, trained fieldworkers will establish relationships with children and their primary care-givers within play-parks and other play areas and environments within which children play and socialize, such as ECDs. *Outreach* will also promote parks and ECDs as child-centred safe, peaceful and health spaces.

The *ECD visitations* will deliver a comprehensive intervention curriculum that addresses safety, peace and health issues. The interventions will involve an assessment of the crèches and follow-up visits to the crèches by fieldworkers, in addition to teacher training and activities with the children over a six month period. The intervention content will address a number of areas, including: infant and child care, immunization and nutrition, prevention of traffic injury, burns and poisoning, prevention of child maltreatment, conflict management and problem solving skills, and organisational support in terms of ECD registration.

Emergency and advocacy services will be provided by responsive trained resource persons. Services will include basic emergency medical and psychosocial care when children sustain injuries in public spaces and making rapid referrals so as to contain the severity and outcome of injuries. The resource persons will mediate hazardous situations and environments that may place children at risk, link individuals and groups to relevant services and resources and facilitate community advocacy action towards securing relevant environmental and design interventions for purposes of safety, peace and health.

The *community mobilization* component is intended to maximize citizen participation and involvement in public events and campaigns designed to encourage child-centred

community cohesion, social control and physical and social order, adult behavioural choices (e.g. nurturant and responsive adult supervision), and environmental arrangements. The public campaigns and events will focus on priority safety, peace and health issues. International and nationally recognized events, such as the World Health Day, World Day for the Prevention of Child Abuse and World Day of Remembrance for Road Traffic Victims, may be used as vehicles to mobilize community action around, key safety, peace and health priorities.

Home Visitation and Strengthening Interventions

The three variants comprise: a core home visitation curriculum and microfinancing and economic solidarity; core curriculum and hazard reduction; and a core curriculum and both the microfinancing and hazard reduction packages.

The home visitation and strengthening intervention will offer a core health and safety curriculum delivered to primary care givers that integrates child health (focussed on nutrition and immunisation) and family functioning, child abuse and unintentional injury (traffic, burns and poisoning) prevention components. The intervention will involve visitors calling 8-10 times on the intervention households over a six month period. The content of visits focuses on two basic issues: i) reducing the stressors that mediate injury and maltreatment, and ii) strengthening the protective factors that will prevent this from happening (Butchart, Harvey, Mian, & Fürness, 2006; Swart, Van Niekerk, Seedat, & Jordaan, 2008).

During each of these visits, trained home visitors will provide the primary caregivers with information on safety practices, complete a related injury hazard checklist, and

discuss possible changes to reduce risks for specific child injury types. Each visit will last approximately 30 to 40 minutes. This curriculum will comprise the core home visitation programme; the core programme will, for some households, be supplemented by additional home visitation components that include either specific safety equipment, or micro-financing based on the principles of economic solidarity.

The *microfinancing and economic solidarity* variation of the home visitation intervention will combine the core health and safety curriculum (Odendaal, Van Niekerk, Jordaan, & Seedat, 2009; Swart et al., 2008), with social empowerment and economic solidarity that resonates with the IMAGE (Intervention with Microfinance for AIDS and Gender Equity) (Pronyk, Kim, Hargreaves, Makhubele, Morison, Watts, & Porter, 2005) and Stepping Stones interventions (Jewkes, Nduna, Levin, Jama, Dunkle, Puren, & Duvvury, 2008). This integration will comprise two components: a poverty-focussed microfinance and economic solidarity scheme, and a health and gender equity component. The primary caregivers will comprise the target group for the intervention; only caregivers who had not received microfinance training before the intervention will be included in the study.

This *hazard reduction* aspect of the intervention will combine the core health and safety curriculum with information on the safe use of a domestic stove and the provision of a designated safe stove. This aspect of the intervention provides specific instructions and demonstrations of the utilisation of one of the paraffin stoves that meet current country-specific South African legislation. Paraffin stoves, despite the hazardous nature of the fuel that they use, are in widespread use in impoverished settings. However, some of the newer such stoves host a number of safety features. These stoves are reported to self-

extinguish when moved, do not explode (because of the physical separation of paraffin and air, except in the burner itself), have reportedly no harmful emissions, have no heated loose parts which may fall on to flammable liquids or materials when knocked over (such as the cooking oil in the pan), and cannot be refueled when alight (e.g. Promethea Corporation, 2009).

Evaluation design

The study is an international, population-based, multi-level, multi-intervention, partly randomised controlled trial. The key design levels are: i) country, ii) community, iii) household primary caregiver/child. Interventions will be undertaken at each level as described below. While the ultimate focus of this trial, and consequently the study sample, are children 0-7, the multi level design implies a target group for each of its levels namely, country, community, and household. Measurements are being undertaken at each of these levels for the purposes of process impact and outcome assessment (see Figure 2).

[Figure 2 about here]

Sample selection

Sample selection will be undertaken at 3 levels, i.e. i) country, ii) community, and iii) household primary carers.

Country. Countries are identified on a purposive basis. A number of research teams involved in child health, safety and peace research and programmes in African countries

were approached to join *Ukuphepha* and participate in the child study. This includes research teams active in South Africa, Mozambique, Egypt and Uganda.

Community. These will be purposefully selected from the participating countries. Within each country, potential pairs of communities as similar as possible in terms of socio-demographic characteristics and health and safety profiles, in which the researchers have some capacity to be involved are identified. Once each pair is chosen, communities will be randomly assigned as the intervention, while the other will be used for comparison purposes. Pre-schools and crèches will be randomly selected from eligible ECD centres within the defined community. Maps of each selected community will be identified and verified for accuracy. Each ECD centre that meets minimum criteria related to facilities, teaching staff, number of children, and child care services will be given a number and a random number generator will be used to identify the centres for the intervention. Community workers will then be allocated to deliver the appropriate intervention to the sampled centres as directed by the study manager.

Household: This is a truly random selection. Randomisation will be performed in liaison with the local study co-ordinating centre using the following process. Maps of each community will be identified and verified for accuracy. Based on earlier studies, eligible households could be ‘families with children 7 years or younger who lived in that house, visited there more than once a month, or stayed there during school holidays’ (Swart *et al.*, 2008, p.184).

Study Sites

There will potentially be 16 communities involved in this stage over three commencement phases. Study sites will include 2 communities per country involved in the study. Phase one study sites are in South Africa, where the full intervention basket is being prepared for piloting and implementation. Phase two study sites will potentially involve communities from South Africa, Egypt, Uganda, Zambia and Mozambique (see Table 1). In phase three, indigenous communities in Australia, and communities from Bangladesh and Malaysia will be added. Phase two and phase three study sites may involve the implementation of the full intervention basket or interventions at selected levels only. Each site will have its own local study centre and there will also be a co-ordinating centre. A description of the phase one and phase two sites is included in the table below.

[**Table 1 here**]

Evaluation

Process evaluation

The process evaluation will focus on the level of community engagement in delivery and the achievement of implementation targets. Qualitative process information will be recorded on an ongoing basis by the study officers, and includes descriptive data regarding staffing, costs of delivery, exposure in the community, participants, growth over time, changes to intervention based on feedback, decision-making and governance issues. Data collection instruments and data collection training manuals are being developed to support community workers record this information.

Impact Evaluation

The impact evaluation will include the administration of a household demographic and risk/protective factor questionnaire to identify injury and selected health risks at household level. A community asset and risk audit to identify assets and risks at community level will be administered. Data collection is to be undertaken by trained assessors in each participating community. Data collectors responsible for the administration of the household risk assessment questionnaire – pre and post study intervention – will be blinded to group allocation. Data collection instruments and data collection training manuals are being developed to support trained assessors record this information.

Outcome evaluation

The outcome evaluation will focus on the effectiveness of interventions. The injury definition used for the intervention specific outcome includes all conditions that can be coded by the external cause codes of the ICD-10; V01-Y36 (inclusive of all causes and all categories of intent but excluding adverse medical events). The measured outcomes include frequency of injury resulting in more than 24 hours abstaining from play, frequency of medically treated injury, frequency of hospital admissions for treatment of injury, and mortality from injury. Injury will be defined by intent (both intentional and unintentional injury are included in the study), nature of injury, body part injured, severity of injury (coded using AIS), and by location, activity at time of injury, and mechanism of injury (coded using ICECI). Data collection is via medical record review which is to be undertaken by trained assessors in each participating community. Data collectors responsible for obtaining injury outcome data – pre and post study intervention – will be blinded to group allocation. Data collection instruments and data

collection training manuals are being developed to support trained assessors record this information.

Ethical and cultural issues

Each of the participating countries would seek ethics approval from a designated national human research ethics authority. Study participants will be informed about the risks involved and the voluntary nature of their and their children's participation. All fieldworkers are to have a list of appropriate child care services to which the child and their caregiver may be referred to and will take the responsibility of arranging referrals and appointments. In cases where the research indicates that the child's safety and health are compromised in any way, we will be obligated and ethically bound to report this to the necessary authorities such as a social worker. Confidentiality will be maintained unless there is evident risk of harm to the child. Assent will be taken from all children participating in the study, while their caregivers will provide written consent. All households except for those belonging to the comparison group for the combined community, ECD and home visitation interventions will benefit by receiving the health, educational and safety packages. These households will be invited to join an intervention that is supported by the findings of the current Ukuphepha implementation.

Conclusion

Despite the self evident appropriateness of the safe community approach and the tremendous support for the movement, the literature indicates that the evidence base in support of such programs is under developed (Spinks *et al.*, 2004; Spinks *et al.*, 2009). In this article we have shown that formal evaluations using high quality study designs are achievable within the safe community context and describe an Africa-centered,

multi-national, multi intervention, partially randomised controlled trial that is currently underway. We have used the principles entailed in the concepts of safety, peace and health to design and develop an Africa-centred child violence and injury prevention study with a view to illustrating how such an initiative may advance the theoretical and scientific basis for the safe communities approach.

The authors recognize that as such the study is an ambitious yet considered contribution towards supporting the development of the safe communities' empirical and theoretical base and examining its relevance and appropriateness for resourced-challenged situations. Notwithstanding the risks and challenges, the study will yield many lessons for data management in large scale international studies, research partnerships and collaborations, and implementing ecologically oriented interventions that locate injuries and violence as cross-disciplinary issues key to the promotion of childhood safety, peace and health.

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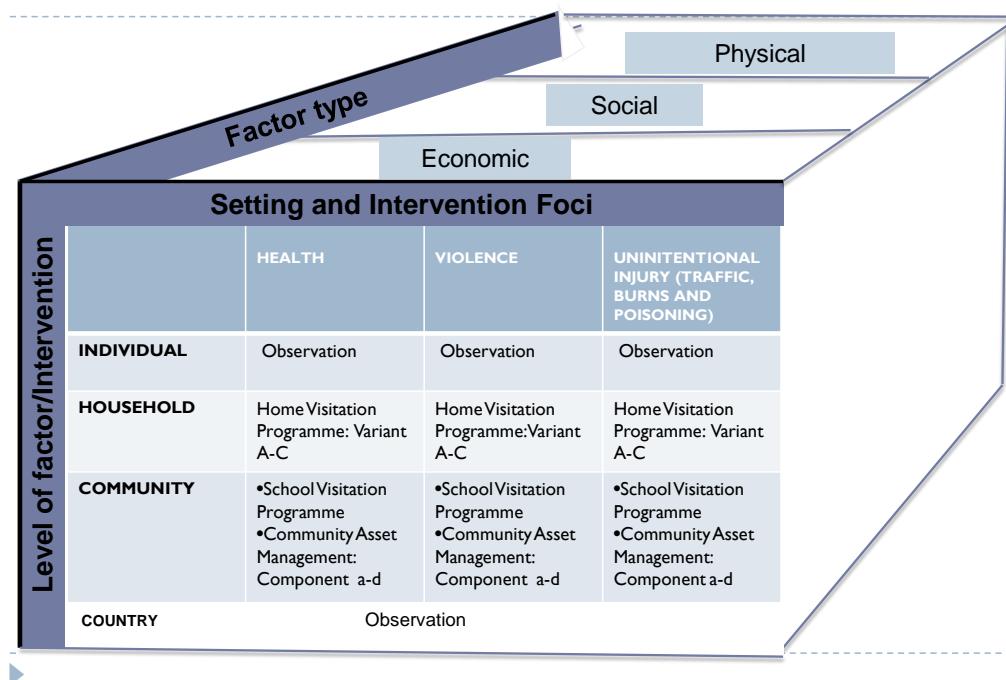


Figure 1. Risk/protective factor and intervention matrix

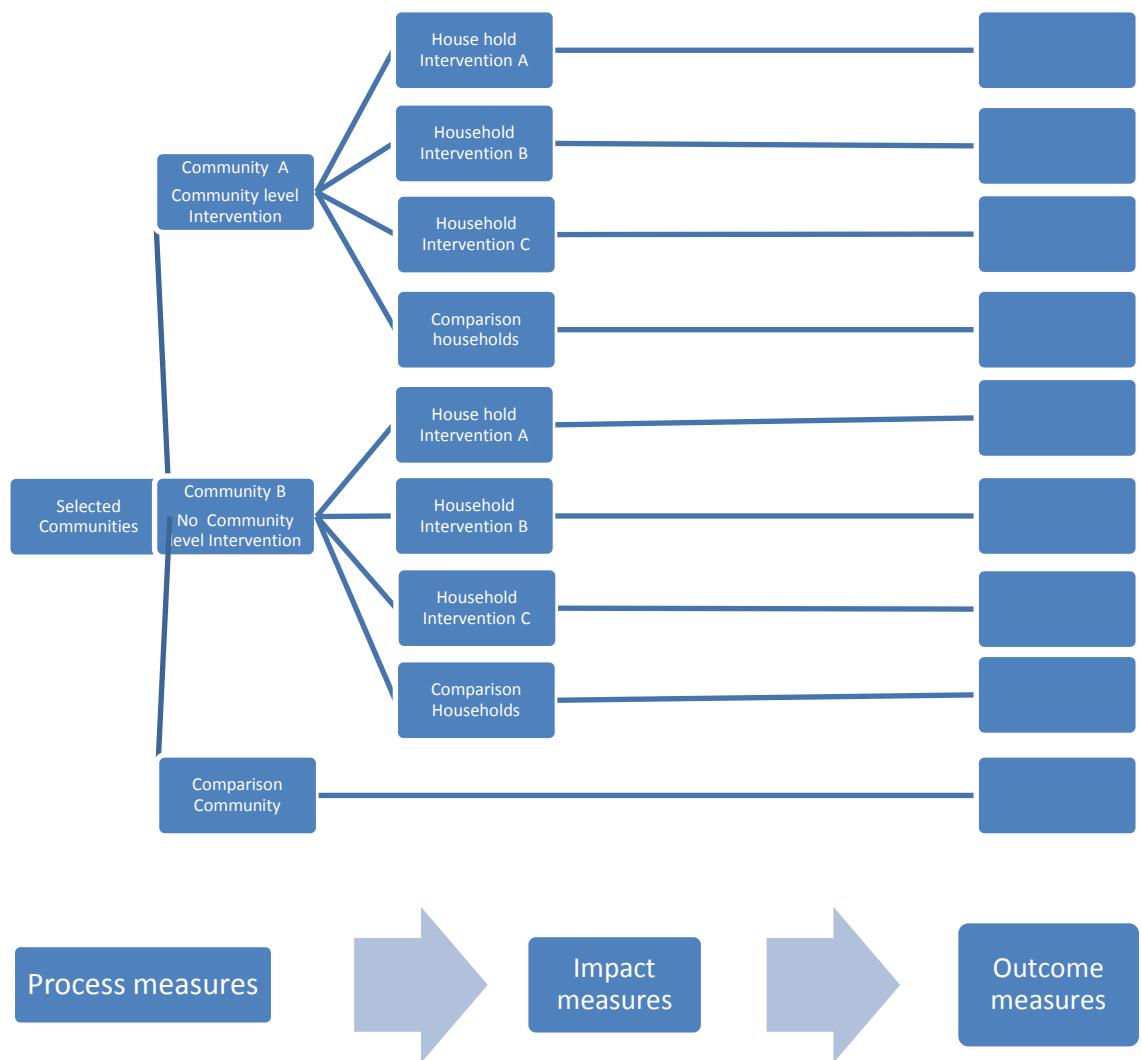


Figure 2. Schematic of study design within each participating country

Table 1. Ukuphepha child study: Phase 2 site information*

Study Site		MACHAVA SEDE	PORT SAID	ISMALIA GOVERNORATE	BWAISE, MAKERERE II COMMUNITY	OPIT	VLAKFONTEIN	NOMZAMO
Study Location		Matola, Maputo Province, Mozambique	North-eastern city in Egypt	Along the west bank of the Suez Canal, Egypt	4km north of Kawempe division, Uganda	Northern Uganda	South of Johannesburg, Gauteng, South Africa	South East of Cape Town, Western Cape, South Africa
Urban or Rural Context		Industrial area (urban and peri-urban areas)	Urban	Urban	Peri-urban	Rural (post-war period)	Urban (low-income, informal settlement)	Peri-urban (low-income)
Community Size:	<i>No. of residents</i> <i>No. of adults</i> <i>Children aged 0-12</i>	34 880 16 853 men & 18 027 women 11 755 children	600, 000 N/A	882,500 23.4% are less than 10 years old	8000 5000 adults	16, 800 N/A	32 000 N/A	±2500 16 250 (65% of population) 7500 children
Community Infrastructure	<i>Schools</i> <i>Clinics</i> <i>Churches</i> <i>NGOs, CBOs</i>	3 elementary 3 secondary 3 technical 2 hospitals 2 health centres 1 private clinic 125 churches; 2 Muslim mosques Approximately 220 active NGO's.	University schools N/A N/A Approximately 220 active NGO's.	713 schools Suez Canal University Hospital N/A N/A N/A	3 primary schools 2 secondary schools, 1 small high institution of learning 3 clinics 2 pharmacies 3 churches 1 home-based Mosque 1 small police post 1 CBO women's organization 1 police post	primary school, secondary school vocation school health unit mission hospital N/A police post soldiers' barracks	crèches 20 pre-schools 2 primary 1 secondary Skills development centre 1 clinic N/A N/A	25-30 crèches 3 primary 1 secondary 1 clinic 3-4 churches 2 NPO's
Housing Types		Mostly made of reed, wood and zinc There are some conventional houses	Urban housing, with slum areas	Urban and rural areas and slum housing	Newly constructed homes are of permanent materials. Old structures are semi-permanent materials.	semi-permanent housing mud and grass structures i.e. temporary housing	6100 formal housing	Mixed housing: ±3500 formal RDP housing, and ±1500 informal dwellings.
Socio-economic profile	<i>Unemployment Rate</i>	N/A	N/A	N/A	N/A	N/A	N/A	±35-40% more women employed N/A
Child (0-12 years) injury patterns and priorities – including availability of existing data, detail of available data	<i>Injury priorities and patterns</i> <i>Available data</i>	N/A N/A	Road traffic injury 82% of child injuries occur in the street; Male children have greater risk for injury.	Road traffic injury, child abuse and maltreatment 0-11 age group, 551 children were injured: falls (60%), road traffic injuries (15%), burns (7%), poisoning (3%), and near drowning/drowning (2%) (Global Childhood Unintentional Injury Surveillance (GCUIS), 2007).	Road traffic, burns and falls. N/A	Violence N/A	Pedestrian injuries, burns, falls, child abuse and neglect N/A Incidents for: Traffic - 17, Burns - 6, Falls - 40 , ± 25% of unintentional injuries for children include poisoning	Road traffic injuries, Burns, Falls Incidents for: Traffic - 17, Burns - 6, Falls - 40 , ± 25% of unintentional injuries for children include poisoning
Existing relationships with community leaders and other stakeholders (e.g. schools, municipality)		NGO's → SAUDECQ, CA-PAZ, AMORTREVO, ADICAE, REMAR; NGO's collaborate with Provincial Department (HIV); Health; City Council; Administrative post; Local Court; local authorities; civil society/church.	Have relationships with community leaders and different stakeholders (e.g. schools, municipality). Partnerships & collaboration between the different sectors such as the health, social and civil sectors. Collaboration with UNISA (2005).	Have good relationships with community leaders and different stakeholders (e.g. schools, municipality). Partnerships & collaboration between the different sectors such as the health, social and civil sectors. Partnerships with various NGO's, Ministry of Health (MOH).	Local community, women's groups, possible coordinator (7 years experience with safety).	Local community, health workers, possible coordinator (10 years experience on school violence).	Partnerships & collaborations with the local civic; local municipality; crèches; local schools; NGOs & government departments (e.g. Community Safety, Human Development).	Partnerships & collaborations with the local civic; local municipality; crèches; local schools; NGOs & government departments (e.g. Community Safety, Human Development).
Current child safety promotion interventions taking place at either household, school or community level		Hosting orphans (HIV); recovery of properties; acquisition of schools supplies, uniforms, school fees; support the generation of income via subsistence agriculture in order to promote self-sustainability.	1998 school pedestrian safety initiative (12-13 years). Safe Community Group 2005 spread the importance of injury and violence prevention at different levels; served the community and assisted in solving problems related to children and safety. Port Said International Schools Initiative (2005) – promoted awareness and prevention of accidental transport injuries. 2007 UN International Week for Road Safety.	The University is involved in many injury control programmes such as RS10 (WHO/MOH joint road traffic injury control). In 2004, the School-Based Program for Injury Prevention and Safety Promotion was implemented in Ismailia city.	A school injury club is located in one of the primary schools). Injury Control Centre – Uganda (ICCU) currently has Injury Prevention Intervention programmes at one of the community schools (focus: burns, traffic injuries).	Planning for injury prevention activities is taking place; Currently, no injury programme.	Child safety campaign: addressing pedestrian safety; burns; child abuse & neglect - implemented at primary schools & crèches.	Child safety campaign: addressing pedestrian safety; burns; child abuse & neglect - implemented at primary schools & crèches.

* Zambia sites in the process of being identified.