The Significance and Limits of the WHO "Safe Community" Approach at the Community Level in Japan

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Keywords; Safe Community, safety promotion, injury prevention, WHO This thesis aims to identify significance and limits of the WHO Safe Community Approach (SC), a movement of safety promotion at the community level, in Japan.

The approach of SC started in collaboration between WHO (World Health Organization) and Karolinska Institutet (Sweden) in 1989. Since then, there have been various studies on SC in the fields of Medical and Public Health, but has been little interest in Social Science. However, as a broad-based issue, the SC approach needs involvement from not only medical and health professionals, but also local governments, police, fire departments, and other safety related organizations, groups and individuals. Therefore, it is meaningful to study about how the SC approach can be applied to Japanese communities in view point of Policy Science.

This thesis consists of two parts with 5 chapters; chapter 1-3 deal with history and background of WHO SC approaches and its introduction among various communities in the word, chapter4 and 5 deals with the case of Kameoka City and discuss on significance and limits of the SC model.

As research methods, literature research was conducted in the first part (chapter 1-3) of this study. Then, for studies on a case of Kameoka City, observation on the process of SC programs, literature research and interview with officials at Kameoka City and Kyoto prefecture were conducted.

As a result of these researches, it has become clear that there was a financial problem at local governments when the injury prevention program firstly started in Sweden in 1970's. Local governments needed to reduce injury for effective and efficient management of Medical and Public Health services.

In 1980's, when WHO established a model of injury prevention program for health promotion on a global level, the Swedish injury prevention program was referred to a great extent. But the aspect of financial issue seems to be left behind in the WHO model.

As for Japan, Kyoto Prefecture became strongly interested in WHO SC program, then Kameoka City was introduced the program as a pilot project. After about 2 years of effort in Kameoka, there are some changes in community.

In Kameoka's case, although the fundamental goal of improvement of safety hasn't been proved by scientific methods yet, some signs of improvement of subjective safety were found.

Besides, secondary effects were recognized; (1) establishment of environment for all SC related actors to share safety related information such injury data and their activities, (2) establishment of system to get whole picture of current situation of safety in community, and then evaluate impacts of SC programs.

On the other hand, a limit of the model has also become apparent. Flexibility or elasticity of the SC 6 indicators can limit development of activities at communities.

At the end, 3 issues which need further research were pointed out; proof of improvement of objective safety, proof of effect on finance issue at local government, and if the original object of the SC model was more focused on safety promotion in development countries rather than its improvement as a whole.