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Tools for empowerment in local risk management ☆

Aud Solveig Nilsen *

Risk Management and Societal Safety, Department of Media, Culture and Social Science, University of Stavanger, 4036 Stavanger, Norway

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Abstract

In local risk management the overall aim is to prevent, reduce and limit injuries and deaths. In Safe Communities (SC) there are many experiences about involvement in local injury prevention but most of the *research* about SC has appeared to be statistical treatment of injury registration. What is lacking in this research is how to supply street level workers with appropriate tools for participation and influence on decisions. Empowerment strategies can improve health and safety promotion in activities at all levels in communities. This implies capacity building, influence and power to the primary users. Mini risk analysis (MRA) has been developed as part of a proactive SC work. MRA is a simple, practical risk tool to be used in local activities. MRA stimulates collaboration, creativity in local solutions, awareness of risks and ways to handle incidents if they occur. MRA and experience from local SC work can contribute to increase involvement in local risk management through enhancing empowerment. The results show how MRA can be used as a practical empowerment tool.

Keywords: Safe Community; Empowerment; Prevention; Health promotion; Risk management

1. Introduction

The Safe Community (SC) movement started in Sweden in 1989 on behalf of WHO and the declaration of health for all (based on the Ottawa charter). The Ottawa charter (1986) underlines the importance of health promotion and community encouragement in preventing injuries and to better people's health. The Safe Community movement has a worldwide network with 16 designated countries and 84 Safe Communities (autumn, 2005). There are specific criteria to follow to be designated as a Safe Community (Rahim, 2005). The SC should have a cross-sectional group where collaboration between different sectors can take place. There is a demand for long-term engagement. Injuries should be registered. Frequencies and causes in the statistical material should be used for injury prevention measures. Continuous evaluation has to be done. Participation

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* Tel.: +47 51 31 71 03; fax: +47 51 83 10 50.
E-mail address: aud.solveig.nilsen@lyse.net

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in conferences and SC networks is supposed to be an ongoing process to learn from others experience both nationally and internationally. Other demands also follow. The Karolinska Institute in Sweden facilitates the WHO Collaboration Centre and designates the SC. There are widespread studies of SC covering the documentation of injury reductions and different projects in injury prevention (Andersson and Menckel, 1995, p. 168; Bjerre and Schelp, 2000; Haglund and Svanstrøm, 1999; Timpka and Lindquist, 2001; Ytterstad and Sogaard, 1995; Lund, 2004).

Challenges and problems when implementing the concept of SC and safety management work has been studied from different perspectives (Boyesen, 1995; Bjärås, 1992; Fosse, 2000; Mikkelsen, 1999, 2000). The aim of SC is to have a holistic approach to mitigation and preparedness, including different sectors and flexible ways of organising work tasks. The bureaucratic organisation can be a barrier to these ideals (Boyesen, 2000). The bureaucratic organisation is designed for standard work with separate budgets and working tasks (Weber, 1976, 1978). Bureaucracies are hierarchical organisations. 'Bureaucracy tends to alienate staff members, and thereby reduce any personal responsibility' (Boyesen, 2000). This structure may therefore suppress new initiatives, which are essential in the bottom-up way of working in SC.

Some studies show that when project leaders quit, SC commitment decreases (Mikkelsen, 1999; Boyesen, 1995). The concluding remarks in Bjärås's Sollentuna study is that professionals have to support the street-level bureaucrats (Lipsky, 1980) to maintain the accident prevention programme (Bjärås, 1992). When including people at an early stage in SC it is more likely that they develop ownership to the SC themselves (Bjärås, 1992). Accident prevention experiences from municipal safety management conclude that some features have to be in place to make the prevention an ongoing process. Safety should be a responsibility for everybody in the municipality (street-level, middle and top level), safety has to be included in both municipal and departmental plans, financial support should be given and procedures for multi-disciplinary coordination should be in place (Boyesen, 1995; ASN translation). It is also essential that SC is grounded at the top level of the organisation in order to achieve support and an ongoing focus. Experiences from SC can be used in local risk management.

There are different strategies to be found in prevention work (Mikkelsen, 1999). The medical science and health planning approaches are top-down strategies where the expert assigns tasks to their subordinates or co-players. There is a middle strategy where the middle level (professionals) in the municipality is mostly concerned with SC work and there is an empowerment strategy that is bottom-up. Forsberg and Starrins book compares the expert (top-down) and empowerment (bottom-up) models to show implications of the different strategies (Forsberg and Starrin, 1997).

There is a poor theoretical description of empowerment processes in SC research, even though empowerment is an important issue in public health traditions (Forsberg and Starrin, 1997; Rifkin, 2003; Rissel, 1994; Wallerstein, 1993). The problem with SC research is that empowerment theory has not been used, although the implicit thoughts in the SC movement are about empowerment.[1] In SC the street level,[2] Lipsky (1980) is supposed to be most important in injury prevention efforts (Mikkelsen, 1999), but SC research has focused on health experts and statistical treatment of injuries. There seems to be a need to develop an empowerment framework in SC to strengthen consciousness about the street-level and how they can be better supplied to effect injury prevention. Although the theoretical framework is lacking a lot of examples of local involvement are prevalent in SC practice. Those experiences can also have relevance for local risk management. Empowerment theory and mini risk analysis (MRA) processes seem to be very interlinked. The aim of this article is to discuss: *How can empowerment be related to risk management and how can MRA strengthen an empowerment strategy in local health promotion and risk management?* The purpose is to give an overview of empowerment in different areas and perspectives and relate those to risk management, which only sparely is covered in research before.

[1] In November 2005 there was a Nordic Safe Community Conference where the theme was 'Community empowerment safety promotion and injury prevention'. This is the first time empowerment has had a main focus in a SC conference. The 6th Nordic Safe Community Conference 9–11 November 2005, Karlstad.

[2] Street level workers; 'interact directly with citizens in the course of their jobs'. Lipsky (1980) *Street-level bureaucracy*, New York, Russell Sage Foundation. For instance teacher, social workers, etc.