Fall Prevention Community of Practice
ADULT+JUNIOR

Addressing Equity, Diversity and Inclusion in Injury Prevention Programs and Policies

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Evidence Summary
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Quick links

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Key Messages

- Injury prevention programs and policies need to address equity, diversity and inclusion (EDI) since the risk of injuries disproportionately impacts populations experiencing conditions such as lower socioeconomic status (SES), racism, and workplace and neighbourhood hazards contributing to injuries.

- Traditional approaches to addressing inequities in injuries have utilized a combination of education, legislation, regulation, modifications to the built environment and targeted programs with varying degrees of effectiveness.

- Many injury prevention organizations have recently extended their focus on EDI through the active engagement of community level partners. Successful community engagement requires shared decision-making power, the active involvement of community members in all phases of data collection and embedding EDI into the organization through hiring staff and/or community members representing the populations of interest.

- While there are a wide range of tools and frameworks to guide the development of EDI-focused interventions, there are relatively few examples documenting the application of these resources to injury prevention topics. This appears to be changing as organizations with an injury prevention mandate have begun to develop their own EDI planning models and frameworks.

- Further applied research is needed to guide the development of EDI-focused interventions across all types of injury. Particular attention needs to be paid to the collection of comprehensive, specific, accurate and inclusive data on the populations at greatest risk of injury.

- In addition to adhering to effective principles of community engagement, practitioners need to consciously avoid inadvertent increases in inequities by applying appropriate combinations of population-wide and tailored, targeted interventions for priority populations.

- Meaningful action to reduce inequities in injury also needs to extend beyond the parameters of injury prevention through programs and policies that directly address the social determinants of health contributing to injuries.

Background

The risk of injury does not affect everyone equally. As with other health conditions (e.g., heart disease), preventable injuries disproportionately impact certain populations due to structural inequities, including those with lower socioeconomic status (SES), lower educational attainment and increased risk of living in housing and neighbourhoods with environmental risk factors contributing to injuries.[1,2]

Disparities in injury rates arising from socioeconomic factors underscore the need to address equity, diversity and inclusion in the planning and implementation of injury prevention programs and policies. The Government of Canada's *Guide on Equity, Diversity and Inclusion Terminology*[3] defines these concepts as follows:

- **Equity** is the principle of considering people's unique experiences and differing situations, and ensuring they have access to the resources and opportunities that are necessary for them to attain just outcomes. Equity aims to eliminate disparities and disproportions that are rooted in historical and contemporary injustices and oppression.
- **Diversity** is the variety of identities found within an organization, group or society. Diversity is expressed through factors such as culture, ethnicity, religion, sex, gender, sexual orientation, age, language, education, ability, family status or socioeconomic status.
- **Inclusion** is the practice of using proactive measures to create an environment where people feel welcomed, respected and valued, and to foster a sense of belonging and engagement. Inclusion involves changing the environment by removing barriers so that each person has equal access to opportunities and resources and can achieve their full potential.[3]

In recent years, awareness of the increased burden of injuries among individuals and communities who are systemically disadvantaged has fostered calls for practitioners to explicitly address equity, diversity and inclusion (EDI) in injury prevention programs and policies. For example, a 2019 report by Giles, Bauer and Jull recommended the expansion of the well-known '3 Es' injury prevention framework (Education, Engineering and Enforcement) to include a fourth E, Equity, in order to reduce unavoidable and unfair risks of serious injuries among socioeconomically disadvantaged groups.[5] In January 2021, the US Academy of Spinal Cord Injury Professionals (ASCIP) formed the Inclusion, Diversity, Equity and Accessibility (IDEA) Committee to focus on EDI in the spinal cord injury community.[6] The 2022 Canadian Injury Prevention Conference convened an EDI panel. Panel members encouraged the consideration of context and culturally and geographically specific factors in planning injury prevention initiatives as well as the active involvement of priority populations in program creation to address their needs.[7]

Purpose

The purpose of this Loop Evidence Summary is to assist practitioners with the incorporation of EDI-focused strategies in the development of injury prevention programs and policies. The document states the case for a greater focus on EDI by providing a brief overview of the scope of injury-related health inequities. It also provides an overview of evaluated injury prevention programs and policies incorporating the principles of EDI as well as EDI planning/assessment tools that have been applied to guide the development of injury prevention initiatives. Lastly, gaps in the current body of knowledge regarding EDI-focused injury prevention are summarized, and recommendations for practitioners and policy makers to advance the use of injury prevention interventions addressing EDI are provided.

Methods

The studies, resources and practical examples cited in this report were from two sources.

First, a literature search on EDI-focused injury and fall prevention was conducted in December 2022. Initially, the search was limited to documentation published in English from the years 2017 to 2022. However, references published before 2017 were included if more recent citations addressing the topic(s) of interest were not available. Databases searched included Google Scholar, PubMed and the Cochrane Database of Systematic reviews. The search strategies included a combination of text words and controlled vocabulary pertaining to the topic (e.g., “equity and fall prevention”).

Second, a request for examples of EDI-focused injury prevention programs and resources was posted to the Health Equity Workgroup (HEWG) member listserv in December 2022. Sponsored by the Ontario Public Health Association, the HEWG is a group comprised of over 60 individuals working in the public and community health sectors. The goal of the HEWG is to identify, recommend and implement strategies that address, diminish and mitigate social inequities in health in Ontario populations.[8]

The need for an EDI-focused approach to injury prevention

There is a strong relationship between risk of injury and SES, with the probability of experiencing preventable injury declining for each incremental increase in income and neighbourhood affluence. This association has been demonstrated across numerous types and causes of injury including falls, suicide, motor vehicle collisions and violence.[9-12] One notable exception to this pattern is sports and recreation injuries, which tend to increase with income. This may be attributable to higher SES individuals and populations having increased opportunities to participate in organized sport/recreation activities.[13, 14]

There are a variety of means through which low SES and inequitable access to the social determinants of health (e.g., education and literacy, safe working conditions, unsafe physical

environments) affect injury risk. For example, low family income and high deprivation levels are potential risk factors for childhood injuries.[15] This may suggest that parents with low-income face challenges adopting proven injury prevention strategies, such as being able to afford protective devices. Parents with low-income often have to work long hours, resulting in decreased time for injury prevention education. Moreover, parents with lower levels of education may lack specific injury prevention knowledge to share with their children.[12]

In some cases, injury can be both a cause and a consequence of socioeconomic deprivation. This 'chicken and egg' relationship can be seen in the link between traumatic brain injury (TBI) and homelessness. A 2019 study by Stubbs and colleagues found that the lifetime prevalence of TBI is 2.5-4 times greater among people experiencing homelessness or marginally housed individuals.[16] However, while homelessness is a risk factor for TBI, TBI may also act to perpetuate homelessness as individuals with TBI experience significant difficulties finding and retaining stable housing.[17]

Certain populations experience additional systemic stressors that put them at greater risk of preventable injuries. Challenges experienced by newcomers to Canada, including language barriers, racism, discrimination and lack of access to appropriate services, can adversely impact their risk of injury.[1] Workers who are new to Canada are more likely to perform physically demanding jobs where they are exposed to occupational hazards.[18] They are also less likely to receive formal job training and information on workplace health and safety practices[18] and do not feel empowered to voice health and safety concerns, ask questions about health and safety, and refuse unsafe duties.[19] It is, therefore, not surprising that workers new to Canada experience higher rates of work-related injury. Using data from the 2003 and 2005 Canadian Community Health Surveys, Smith and Mustard found that during their first five years in Canada, male newcomers reported twice the rate of work-related injuries requiring medical attention compared to Canadian-born male workers.[18]

The complex interaction of racism, socioeconomic deprivation, deficits in the built environment (e.g., unsafe housing) and the legacy of colonialism contribute to significantly higher rates of injuries among Indigenous peoples in Canada (First Nations, Métis and Inuit) than non-Indigenous Canadians.[20, 21] The magnitude of disparity in injuries between Indigenous and non-Indigenous populations in Canada may actually be under-estimated due to a lack of data on key subpopulations (e.g., falls among the Inuit).[20]

Addressing EDI in injury prevention initiatives

Inequities in preventable injuries have traditionally been addressed through a combination of education (both population-wide and targeted to specific groups), legislation, regulation, modifications to the built environment and targeted subsidies for low-income households. Examples of the latter include the provision of stair gates,[22] window locks[23, 24] and booster seats.[25]

A comprehensive analysis of the impact of these interventions on inequities in injury rates was conducted by Zambon and Loring as part of a guidance document for the European Region of the World Health Organization.[2] Using Haddon's ten strategies for injury prevention,[26] the authors matched corresponding interventions with each strategy and assessed their impact on the reduction of inequities in injury. A modified summary table of the results is presented in Appendix A.

Interventions that had a greater impact on reducing injuries among low SES groups included:

- education and subsidy programs relating to the use of stair gates to prevent falls in children (separate the hazard);[22]
- education programs related to the prevention of thermal injuries, including burns and scalds (modify the hazard);[23]
- bicycle helmet legislation (equip the person);[27]
- interventions to prevent drowning in children (supervise the person).[23]

Some interventions were found to have an equally beneficial impact in reducing injuries across all socioeconomic groups. These included:

- changes to the built environment, such as the installation of barriers/fencing (isolate the hazard);[2]
- traffic calming measures, such as speed bumps (modify the hazard);[28]
- the provision of smoke detectors (equip the person).[22, 29]

Although many traditional injury prevention strategies have yielded positive impacts in the reduction of inequities, the development of initiatives with the explicit goal of addressing inequities in injury is a relatively recent phenomenon. To gain insight into how organizations with an injury and/or violence prevention mandate were incorporating equity approaches into their work, the US Centers for Disease Control and Prevention (CDC) and the Safe States Alliance conducted an environmental scan in 2021.[30] Data collection methods included surveys and a series of focus groups with injury prevention practitioners employed at state health departments, local health departments and hospital-based programs.

The scan found that 81% of the surveyed organizations were addressing health equity. Examples of equity-focused strategies and associated challenges identified by respondents are summarized in Table 1.

Table 1. Equity-Based Injury and Violence Prevention Strategies. Examples and Challenges.[30]

Examples	Challenges
Sharing ownership and decision-making power with community-level partners, including facilitating empowerment among community leaders/members to identify and address contributing factors for injuries/violence.	These types of partnerships are relatively new. Can be a challenge to establish a shared understanding. Low community participation in injury/violence prevention programs due to limited access to populations of interest.
Even complex programs can be successfully implemented when partners can identify common ground and 'win-win' intervention strategies. Going beyond translation of educational materials to address cultural sensitivity and health literacy.	No alignment among funding sources to support collaboration with community partners.
Engage community level partnerships to assist in primary data collection/conducting community assessments.	Injury/violence prevention datasets have limited demographic fields/variables that impact ability to identify inequities.
Analyze existing datasets to identify subpopulations that are disproportionately impacted by injuries. Engage community partners in interpreting data to ensure its relevance to community needs.	Some injury/violence prevention programs lack access to an injury epidemiologist or skilled staff to analyze and interpret equity-related data.
Incorporate EDI principles into the organization by changing hiring practices. Make an organizational commitment to advance health equity and align equity approaches with jurisdiction-level work plans and funding priorities.	Internal obstacles to hiring diverse staff with workforce skills, cultural competencies or lived experience.

One over-arching finding of the scan is that, even among the 81% of organizations addressing equity in injury and violence prevention, many are new to this type of work. The developmental nature of equity-focused injury/violence prevention presents an opportunity for innovation as well as the sharing of emergent best practices with funders and the field at large.[30]

As the scan illustrates, extensive community engagement, including shared ownership and decision-making power with community partners, is an essential component of EDI-focused injury prevention efforts. It is also imperative that this community engagement be conducted in accordance with the cultural beliefs, norms and values of the priority population. Two recent fall prevention initiatives developed with Inuit and Indigenous communities serve as helpful illustrative examples (see below).

Initiatives in fall prevention

Participatory action research with Inuvialuit Elders

Frigault and Giles undertook a participatory action research project to develop fall prevention recommendations for Inuvialuit Elders in Inuvik, Northwest Territories.[31] The project arose from a concern about the lack of culturally safe fall prevention programs available to Inuit Elders. Cultural safety refers to understanding the impact of colonization, colonial relationships and power dynamics on health services.[32] A culturally safe approach to developing fall prevention initiatives aims to redress the power imbalance between researchers/practitioners and participants, and to ensure that health professionals respect and acknowledge the historical and lived experiences of participants.[31]

A series of semi-structured interviews with Elders and local fall prevention programmers identified three components of a recommended fall prevention program for Inuvialuit Elders: environmental assessment and modification addressing the living conditions of the Elders (e.g., crowded indoor conditions with trip hazards (e.g., throw rugs, lack of assistive living devices, extremely low temperatures and icy surface conditions), physical activity interventions (with an emphasis on physical activities with the greatest likelihood of reducing overall fall risk) and fall prevention education for Elders and caregivers. Participants felt that fall prevention education for Elders should focus on increased awareness about the importance of fall prevention, emphasizing that preventing falls is possible, and promoting effective strategies to prevent falls, such as personal safety checks.[31]

Participants felt that these interventions needed to be made culturally safe for Elders through three strategies. First, establishing trust and rapport within the community is integral to gain a better understanding of the fall risks of Inuvialuit Elders. Greater levels of trust and rapport can be achieved through community capacity building and the promotion of open dialogue. Second, including both Indigenous (e.g., traditional exercises such as trapping or fishing) and non-Indigenous interventions in fall prevention programs helps to ensure the cultural safety of fall prevention initiatives. Lastly, cultural safety practices training reduces the likelihood of fall prevention professionals imposing their values and beliefs on Elders.[31]

The Ironbark program in New South Wales

Key principles of community engagement were incorporated into the Ironbark program, a fall prevention program for Aboriginal communities in New South Wales, Australia.[33] These included local Aboriginal control (i.e., offered through Aboriginal health services and administered by Aboriginal staff), culturally relevant resources and activities (such as the use of traditional story-telling 'Yarning Circles' to discuss program topics) and tailoring the program in accordance with participant feedback identifying community needs. The program can be offered as a stand-alone intervention, or for incorporation into broader healthy aging initiatives for Aboriginal communities.[33]

The Ironbark program consisted of an exercise component and an education component. The exercise component was based on 14 core leg muscle strengthening and balance retraining exercises developed as part of the Otago Home-Based exercise program. The education component of the Ironbark program relied on facilitated group discussions that encouraged participants to make informed lifestyle changes to reduce fall risk. Each discussion was facilitated as a traditional Aboriginal 'Yarning Circle', and a Yarning Circle manual with information on fall risk factors was created to assist program facilitators. Participants handouts based on the Yarning Circle manual content were also developed.[33]

A pilot test of the Ironbark program with 77 Aboriginal people in six communities found significant improvements in participant leg strength, balance and gait. A significant decrease in the body mass index of participants was also observed. Participants enjoyed the program and were willing to recommend it to others.[33]

Tools and resources for developing EDI-focused injury prevention initiatives

While there are a wide range of frameworks to guide the incorporation of EDI principles into the development of public health programs and policies, there are relatively few published analyses documenting the use of EDI tools and resources to plan injury prevention initiatives. As a follow up to the release of the CDC's Core Health Equity Strategy in early 2021, Lennon, Carmichael and Qualters conducted a review of health equity guiding frameworks to better ascertain which of these had been applied to injury prevention topics.[34]

The review identified 60 frameworks relevant to health equity; however, only three were utilized to address an injury-related topic. They were 1) the Cochrane Methods PROGRESS (Place of residence, Race or ethnicity, Occupation, Gender, Religion, Education, Socioeconomic status, and Social capital) Plus framework,[35] 2) the WHO Social Determinants of Health Conceptual framework[36] and 3) a modified socioecological framework focusing on the interrelationship of the social determinants of health (SDOH) across five different levels: individual, interpersonal, organizational, community and public policy.[37] The authors concluded that further work is needed to determine which planning frameworks are most appropriate for addressing health equity in injury-specific topic areas.[34]

There is some evidence of emerging injury-specific equity planning frameworks as more organizations with an injury prevention mandate commit to addressing EDI in their scope of practice. A recent Canadian model, Transforming Injury Prevention for Youth (TrIPY) is designed to address and remediate inequities in injuries among youth through the application of an intersectionality lens to injury prevention programming.[38] Intersectionality is an analytical term focusing on the ways in which different social stratifiers (e.g., gender, class, race, education) interact to create different health outcomes for different individuals and groups.[39] The multi-dimensional TrIPY model places 'Youth Injury' at the centre and overlays it with multiple intersecting factors operating at different levels of society. These include Intersecting Social and Biological Identity Factors (e.g., gender and sexual orientation), Intersecting Systems and Outcomes of Oppression (e.g., racism) and Intersecting Social, Political and Economic Forces (e.g., the legal system). By identifying and exploring the intersectionality of factors shaping the unique experiences of youth, injury prevention programs can become more culturally responsive, gender transformative, inclusive, accessible and engaging to diverse groups of young people.[38]

In 2021, the US Children's Safety Network released a health equity planner to guide the development of community-level child safety strategies.[40] The resource is designed to facilitate planning with key stakeholders on the integration of health equity into child safety programs through a five step process: identifying the SDOH(s) impacting the problem, planning the necessary scope of work, determining responsible leadership and management within the organization, engaging community stakeholders with child safety expertise and ongoing systems improvement in order to address gaps and ensure continuous quality improvement.[40]

Knowledge gaps/implications for research and data collection

A 2019 scoping review of research in injury disparities conducted by Moore and colleagues provides a comprehensive summary of current knowledge gaps in injury prevention initiatives addressing EDI.[41] The review identified the need for further applied research on the development of preventive interventions to reduce health inequities across all types of injury. Particular attention needs to be given to further research on the development of public health campaigns addressing inequities in injury, injury inequities in the post-acute and rehabilitation sectors and the development of policies aimed at reducing inequities in injuries.[41]

The challenges of addressing EDI in the development of injury prevention interventions are compounded by a lack of comprehensive, specific, accurate and inclusive data on the priority populations at greatest risk of injury. Data sources with indicators for diverse populations as well as comprehensive injury and outcome data are limited. Specifically, the further disaggregation of data sets by key variables (e.g., race/ethnicity, socioeconomic status) is critical for better understanding the unique needs and circumstances of those who are most impacted by higher rates of injury.[41]

In addition, injury data surveillance systems need to capture the range of social determinants of health associated with injury rates. Access to this information ensures that practitioners are able to focus on priority populations with the greatest risk of injuries linked to factors such as age, sex, employment status, income, educational attainment, social support and the built environment.[1]

Last, further efforts to apply the participatory, empowerment-facilitating principles of community engagement and community action research are needed to increase current knowledge of best practices in collaborating with at-risk groups to identify and address the risk factors contributing to inequities in injury. Community-based participatory strategies have proven to be effective in engaging communities in taking action on shared health priorities,[42, 43] but more work is needed to apply these strategies in the field of injury prevention.[41]

Implications for practitioners and policy makers

In the CDC-sponsored environmental scan on how injury prevention organizations were incorporating EDI principles into their work, the one activity repeatedly identified as critical for success was engaging community members in the development of injury prevention strategies.[30] In practice, effective community engagement for EDI-focused injury prevention entails three key components:

- sharing decision making power and ownership with community members;

- engaging community members before collecting data and actively involving them in the collection and interpretation of data;
- building EDI into organizational infrastructure by having staff and/or community members representing the priority populations engaged throughout the initiative.[30]

Shared decision making and ownership often takes the form of providing expertise and evidence-based practices to community members, who then modify interventions to be more culturally appropriate and relevant to their needs.[30] This was the approach employed by the Australian Ironbark program (see page 8), where representatives of Aboriginal communities worked with Aboriginal fall prevention practitioners to ensure that fall prevention activities were aligned with the cultural beliefs and preferences of participants.[33]

Traditional injury prevention strategies have focused on population-level primary prevention, with emphasis on the '3 Es' of Education, Engineering and Enforcement.[1, 4] While these interventions are important, there is a risk that they can inadvertently serve to increase inequities in injury if they do not consider the social, economic and cultural factors that inform people's everyday realities.[1, 2] For example, the benefits of legislation requiring the installation of mandatory carbon monoxide detectors would not extend to households unable to afford them, or a community-based fall prevention exercise program for older adults would not benefit those who do not have access to transportation or the program not incorporating their cultural preferences regarding physical activity.

Avoiding the inadvertent increase in inequities through injury prevention initiatives requires a combination of universal, population wide approaches, including legislation, regulation and community-based initiatives, with tailored, targeted interventions (e.g., subsidies to purchase carbon monoxide detectors) for priority populations at greater risk of injuries.[2] This approach is known as proportionate universalism, which addresses inequities through a balance of universal and targeted approaches to meet the needs of populations across the health gradient.[44]

Last, practitioners and policy makers need to be aware that meaningful actions to reduce inequities in injuries must act upon the root causes of inequities through policies and interventions that directly address determinants of health and injury such as low income, poor housing, precarious employment, racism and unsafe working conditions. In addition to reducing inequities, these measures have also been found to have a positive impact on injury rates. For example, a Housing First program, which provides people experiencing homelessness with immediate access to permanent housing, was found to reduce injury-related hospital admissions among members of this population.[45] Programs and policies aimed at providing equitable access to the social determinants of health will also increase the effectiveness of injury prevention strategies, as individuals will be more receptive to interventions such as education when their basic needs have been met.[1]

Key Loop Resources on Equity, Diversity and Inclusion

Webinars

Being an Influencer for Social Policy – An Injury Prevention Perspective (2021)
Delivered by Chantal Walsh, a Health Promotion Specialist with the Child Safety Link (CSL), and Jennifer Russell, Executive Director of the Atlantic Collaborative on Injury Prevention (at the time of the webinar), this webinar engaged stakeholders who work in fall prevention to reflect on and discover ways in which social policies can address the links between the social determinants of health and fall-related injuries across the lifespan. The webinar can be viewed at https://www.youtube.com/watch?v=RLCGx4Uh3i8

Fall Prevention and the Social Determinants of Health Across the Life Span (2019). Delivered by Sandra Newton, Manager of Child Safety Link (CSL) at the IWK Health Centre in Halifax NS, this webinar focuses on how the social determinants of health influence falls across the life span. The webinar can be viewed at https://www.youtube.com/watch?v=GCyWxy7KoGM

Loop Discussion Threads

Release of New ACIP & CSL Report: Being an Influencer for Social Policy: An Injury Prevention Perspective (last activity – February 8, 2021).
https://www.fallsloop.com/discussions/11435
This post announces the release of ***Being an Influencer for Social Policy: An Injury Prevention Perspective***. Produced by the Atlantic Collaborative on Injury Prevention (ACIP) in partnership with Child Safety Link (CSL), the document serves as a guide for stakeholders to identify their role in influencing social policy that supports injury prevention. This document offers broad examples of the roles stakeholders from across the injury prevention spectrum can have in various activities of the social policy process. A copy of the report is available at https://policycommons.net/artifacts/1886555/being-an-influencer-for-social-policy/2635870/

Creating safe virtual spaces for marginalized older adults (Last activity – July 21, 2020).
https://www.fallsloop.com/discussions/11344
This discussion notes an Alliance for Healthier Communities webinar on strategies utilized by program staff across four Alliance member centres to create virtual spaces that are safe, accessible, and welcoming for marginalized older adults who experience challenges accessing and using on-line technologies. The webinar slide deck is available at https://km4s.ca/wp-content/uploads/lnl-safe_online_spaces_for_m.pdf

Are you interested in joining our Indigenous Fall Prevention Network? (Last activity – September 30, 2019).
https://www.fallsloop.com/discussions/10996?viewcomment=1655#CM1655
A private group has been created to discuss, share and access information, and to network around opportunities to share resources, to learn about funding opportunities, ask questions and discuss issues relevant to fall prevention among Indigenous populations in Canada.

New Report from ACIP - Seniors' Fall Prevention and the Social Determinants of Health: A Social Policy Lens (Last activity – June 26, 2019).
https://www.fallsloop.com/discussions/11160
The Atlantic Collaborative on Injury Prevention (ACIP) has released a report titled ***Seniors' Fall Prevention and the Social Determinants of Health: A Social Policy Lens***. The report builds on several existing documents on fall prevention and is inclusive of evidence-based interventions currently available across Canada and within Atlantic Canada. The report breaks down existing social policy examples (by Atlantic Province) and provides a brief description of how each of these social policy examples link to the social determinants of health and seniors' fall prevention. The report is available at http://www.acip.ca/Document-Library/Seniors%27%20Falls/Final%20English%20ACIP_Seniors%20Fall%20Prevention%20Report_May%202019.pdf

Modifying and orienting interventions and services to reduce health disparities for marginalized and priority populations (Last activity – July 27, 2017)
https://www.fallsloop.com/discussions/10623?viewcomment=1020#CM1020
This post provides an overview of strategies, tools and resources to assist practitioners with critically examining a program or service to understand its effect on health disparities, then changing the way it is designed or delivered.

Home safety assessment and modification to reduce injurious falls in community-dwelling older adults: cost-utility and equity analysis (Last activity – August 22, 2016)
https://www.fallsloop.com/discussions/10374
This post provides a link to a study on home safety modification as a means of reducing falls among community dwelling older adults. The study includes an equity assessment, and is available at https://pubmed.ncbi.nlm.nih.gov/27222247/

Social Determinants of Health - Reading List (Last activity – November 4, 2015)
https://www.fallsloop.com/discussions/10198
This post provides a list of recommended readings on the social determinants of health.

Appendix A: Haddon's 10 Strategies for Injury Prevention and their potential impact on Inequities*

(* Excerpt from Zambon, F., Loring, B. Injuries and Inequalities: Guidance for addressing inequities in unintentional injuries. Copenhagen: WHO Europe, 2014.)

Strategy for Injury Prevention	Type of Intervention	Aim of Intervention	Examples	Impact on Inequities
Eliminate the hazard	Legislation, regulations, infrastructures	Limiting exposure		Likely to increase safety for all
Separate the hazard	Legislation, regulations, infrastructures, provision of safety devices	Limiting exposure	Falls: stair gates	Education programmes related to the use/ possession of stair gates were more effective among at-risk families compared to their controls
			Falls: window locks	Education programmes related to the use/possession of window locks were less effective among disadvantaged families compared to their controls
Isolate the hazard (time and space)	Legislation, regulations, infrastructures	Limiting exposure	Fencing for public aquatic facilities/ locations; installing barriers for cliff edges	Likely to increase safety for all

Appendix A: Haddon's 10 Strategies for Injury Prevention and their potential impact on Inequities (Continued)

Strategy for Injury Prevention	Type of Intervention	Aim of Intervention	Examples	Impact on Inequities
Modify the hazard	Legislation, regulations, infrastructures	Limiting exposure	Scalds: safe hot tap water temperature	Education programmes related to thermal injury prevention were more effective in disadvantaged families compared to their controls
			Road traffic injuries: traffic calming	Traffic calming is associated with reduction in absolute pedestrian injury as well as reduction in relative inequities in child pedestrian injury rate
			Burns: flame resistant nightwear	Does not prevent injury, but significantly contributes to the reduction of fatal injuries for members of all social groups
Equip the person	Safety standards, pricing policies of safe equipment, free distribution of safe equipment	Limiting vulnerability	Road traffic injuries: legislation on bicycle helmets	Bicycle helmet legislation is effective in increasing helmet use by all children and particularly those in low-income areas
			Fires: smoke detectors	Equal impact on all socioeconomic groups
Train and instruct the person	Home visiting programmes, social marketing campaigns, training courses, law enforcement	Limiting vulnerability	Road traffic injuries: population-based education programmes combined with affordability and accessibility of cycle helmets	Programmes had a positive impact on head injuries both in rich and poor municipalities
Warn the person	Home visiting programmes, social marketing campaigns, training courses, law enforcement	Limiting vulnerability	Road traffic injuries: population-based education programmes combined with affordability and accessibility of cycle helmets	Programmes had a positive impact on head injuries both in rich and poor municipalities

Appendix A: Haddon's 10 Strategies for Injury Prevention and their potential impact on Inequities (Continued)

Strategy for Injury Prevention	Type of Intervention	Aim of Intervention	Examples	Impact on Inequities
Supervise the person	Parenting programmes, law enforcement	Limiting vulnerability	Interventions to prevent drowning	More impact on disadvantaged groups
				Likely to increase safety in disadvantaged groups
Rescue the person	Improving trauma care in deprived areas, increasing accessibility and affordability of care	Improving health outcomes		Likely to limit long-term consequences of injuries in disadvantaged groups
Repair and rehabilitate the person	Increasing accessibility and affordability of care, social welfare, social protection	Limiting health consequences		

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