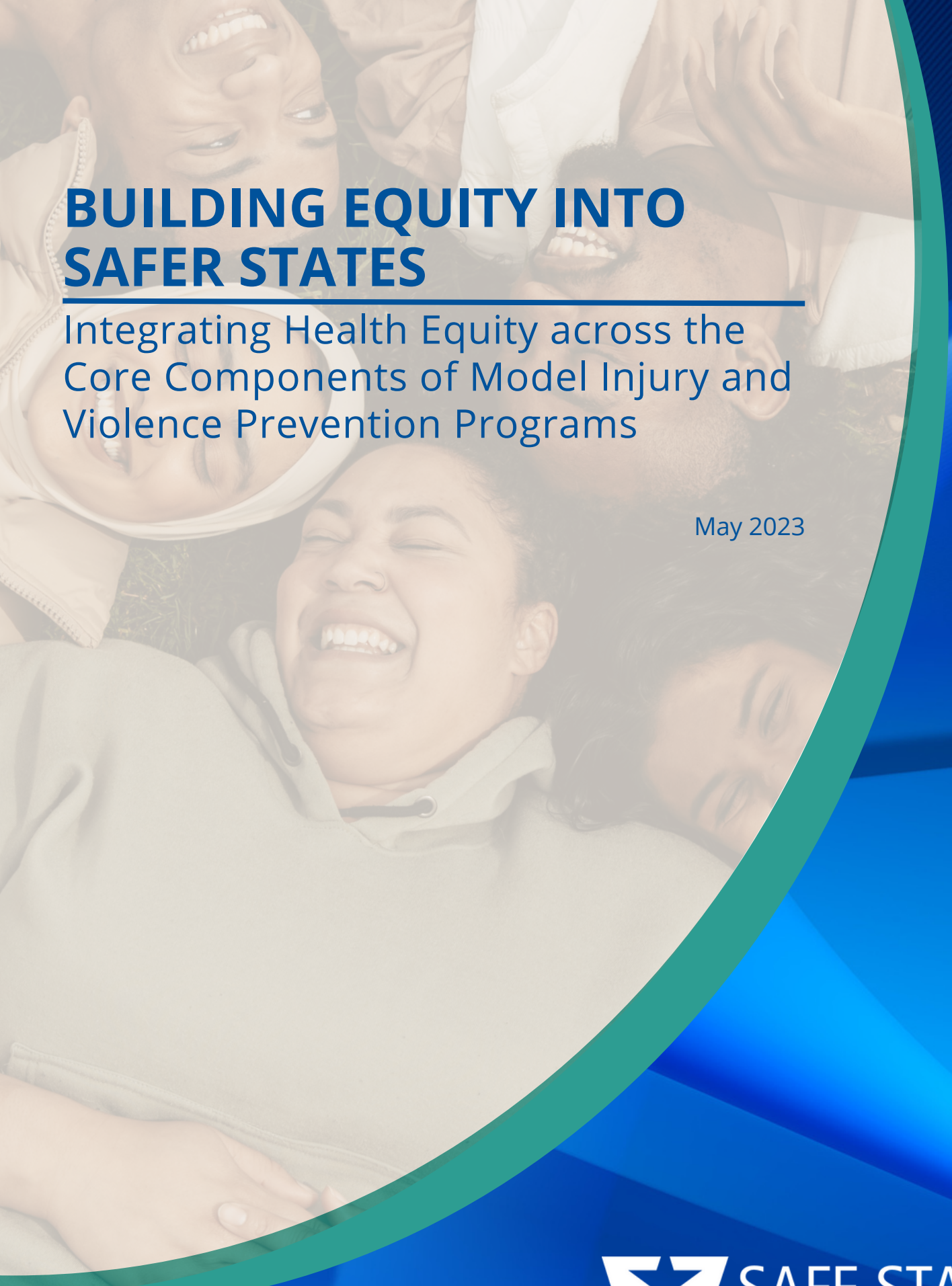

BUILDING EQUITY INTO SAFER STATES

Integrating Health Equity across the Core Components of Model Injury and Violence Prevention Programs

May 2023

SAFE STATES

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Building Equity in Safer States: Integrating Health Equity across the Core Components of Model Injury and Violence Prevention Programs. (2023). Atlanta (GA): Safe States Alliance.

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The Safe States Alliance is a national non-profit 501(c)(3) organization dedicated to serving as the national voice in support of injury and violence prevention professionals engaged in building a safer, healthier America. Founded in 1993, the Safe States Alliance is the only national non-profit organization comprised of public health injury and violence prevention professionals representing all states and territories in the United States.

ACKNOWLEDGEMENTS

Safe States Alliance's **strategic priorities** encompass a central challenge to the organization of leading and elevating the field of injury and violence prevention (IVP) through an anti-racism and health equity lens. To help meet that challenge, Safe States has taken several significant actions, including:

- Launching an **Anti-Racism and Health Equity Work Group** with the purpose of engaging a core leadership team of diverse members and partners in a unified approach toward achieving equitable opportunities and positive health outcomes for all marginalized groups;
- Conducting an **IVP Health Equity Scan** to explore how injury and violence prevention professionals advance health equity and racial equity in their programmatic work;
- Hosting an **Injury and Violence Prevention Network (IVPN) Equity Convening** to identify opportunities for the IVP field to collectively realize a vision for addressing inequities through partnership and policy activities;
- Developing an **Equity in Injury and Violence Prevention Vision and Call to Action** inclusive of recommendations for community engagement, partnership activities, and policy initiatives; and
- Expanding non-traditional partnerships with equity-focused organizations.

As a thought leader providing guidance to state health departments, Safe States disseminates the most recent data and strategies that promote diversity, equity, and inclusion across the IVP field. This resource is intended to serve as a guide to incorporate a health equity lens into the IVP "Core Components" for state health departments as defined in ***Building Safer States, 2013 Edition***. *Building Safer States* defines and expands on a set of essential "core components" – foundational elements of a model state-level IVP Program.

This resource document was developed with contributions from the Anti-Racism and Health Equity Work Group, a group comprised of Safe States members with cross-sector backgrounds in IVP programs, policy strategies, epidemiology, research, evaluation, and coalition building. The editorial process for this report was overseen by Richard Hamburg, MPA, Safe States Executive Director and Sharon Gilmartin, MPH, Safe States Deputy Director. Technical writing and research for this resource were provided by Safe States staff: Ina Robinson, MPH, Senior Manager for Programs and Health Equity, Deltavier Robertson, MPH, Manager of Programs and Health Equity, Taylor Mayberry, MPH, Health Equity Fellow, and Christine Anyanwu, Health Equity Practicum Student.

INTRODUCTION

Injuries and violence can occur at any age and in any community. Yet, like other public health events, injuries and violence do not occur at random. They follow patterns that can be detected, interrupted, and ultimately prevented. Injury and violence prevention (IVP) professionals pursue every opportunity to anticipate injuries and violent events before they occur, so that these events never happen in the first place. IVP efforts provide safety across the lifespan. When prevention efforts are successful, they provide the opportunity for children and youth to grow up to live to their fullest potential.

Although there has been success with IVP prevention efforts, economically and socially marginalized populations continue to be disproportionately affected by unintentional injury and violence. For example, a study in 2017 reported that racial minorities and low-income populations are disproportionately affected by traffic-related deaths and injury. It was noted that these populations often lived in communities that lacked transportation infrastructure, such as functioning streetlights, and were saturated with land uses such as liquor stores that are associated with unsafe driver behavior.[1] In 2020, approximately 6,871 youth ages 10-24 died due to homicide violence, with the majority of the youth being Black.[2] Household poverty, neighborhood deprivation, and the systemic effects of racism contributed to the disparity in youth violence.[3]

These examples are only a sampling of the many inequities across IVP outcomes, yet they highlight the impact that social determinants of health (SDOH) can have on a population's risk of unintentional injury and violence. These determinants include "structural determinants," such as socioeconomic status and community/societal context, and "intermediary determinants," such as the living and working conditions of people. Socioeconomic and political risk factors include structural racism practices (e.g., redlining, segregation, war on drugs, stolen land) which in turn influence community risk factors such as community deterioration, higher access to illicit substances and weapons, academic underachievement, and incarceration rates. Those community risks trickle down to families and individuals, affecting their physical and mental health, behaviors, and working conditions. As IVP programs strive to improve their interventions and programs, it will be essential to adopt a health equity lens to truly address these underlying structures driving the ongoing inequitable distribution of the burden of injuries and violence. Applying a health equity lens goes hand in hand with anti-racism, which is the practice or policy of actively opposing racism and promoting racial equity. **Health equity is the assurance of the conditions for optimal health for all people.**[4] By using a health equity lens, IVP professionals can address or improve the factors that persist in economically and socially marginalized populations causing injury and violence-related health inequities.

The original ***Building Safer States*** document was developed primarily for those involved in state-level IVP efforts. However, history has demonstrated that the core components of a model IVP program are applicable in a variety of practice settings. As foundational elements of capacity, the core components are useful to anyone working to enhance the effectiveness of their IVP programs, no matter where they may be. As we reimagine traditional IVP practices and incorporate diversity, equity, and inclusion (DEI) practices into the IVP core components, this accompaniment to the 2013 edition of ***Building Safer States*** will support the work of IVP professionals, advocates, funders, researchers, elected officials, and the many other partners who are working to prevent injuries and violence. Integrating anti-racism, health equity and DEI principles within each core component is essential, and it is crucial to consider these principles across every decision made within an IVP program.

Finally, links to tools and resources will be included throughout the document for those interested in additional detailed information. These include relevant public health frameworks, evaluation resources, and IVP burden data. The combination of core component descriptions, examples from state IVP programs, and insights about opportunities and challenges will provide a current snapshot of state IVP programs today — and where they can move in the future.

THE INEQUITABLE BURDEN OF INJURIES & VIOLENCE

Overview

Nearly 243,000 Americans lose their lives to injuries or violence each year and succumb to falls, car and bicycle crashes, homicides, suicides, unintentional poisonings, fires, and drownings.[5] According to 2020 data from the Centers for Disease Control and Prevention (CDC), injuries caused more deaths among people ages 1-44 than infectious and non-communicable diseases combined.[6] Even though these instances are not specific to any race, gender, socioeconomic status, culture, or age, they don't affect all individuals and communities equally. Homicide is the leading cause of death for African Americans, Asians and Pacific Islanders, and American Indians and Alaska Natives between the ages of 10 and 24 and is the second-leading cause of death for Hispanics within the same age range.[7] Those same racial groups have higher instances and longer-standing impacts of child maltreatment and suicide and have more individuals living in urban low-income communities; these are not coincidences. Marginalized communities generally have poorer health outcomes in comparison to their white counterparts across many health arenas, not just injury and violence. Even though it's important to minimize injuries and violence across all demographics, there is a need to dial into the inequities that drive disproportionate burdens of injury and violence among marginalized communities. To create equal opportunities, IVP must be tailored to each community to obtain the best results.

The integration of health equity into the six core components of model IVP programs described in this document recognizes the resource constraints under which state IVP programs operate, but also reflects the creativity, flexibility, and innovation state programs have used to strengthen and expand their work. This document will emphasize the importance of integrating health equity practices into state-led efforts and provides additional resources for deeper learning on the associated topics.

FRAMING IVP THROUGH A HEALTH EQUITY LENS

Safe States visualizes a future in which policies and practices are community-driven, past harms have been acknowledged, historically marginalized voices are elevated, and all sectors connect to invest in addressing the legacy of structural racism and eliminating inequities that drive injuries and violence, and other adverse outcomes. Racial and health inequities in the United States have existed since the founding of colonial America and have been well-documented by governmental statistics.[8] Pervasive inequities remain embedded into many of the country's systems (e.g., healthcare, housing, criminal justice, education, built environment), and scholars continue to examine and identify structural racism as a critical social determinant of health. Intersectionality also adds another layer to identifying SDOH and interventions to dismantle the country's current systems of oppression. Intersectionality - a term coined by Kimberlé Crenshaw, a civil rights activist, professor, and legal scholar - is used to describe intersections of marginalized identities, such as being a person of color, being disabled, being low-income, or being an older adult. When you have multiple marginalized identities, they intersect and compound the impacts of multiple forms of oppression. Individual people experience these multiple forms of oppression, but because we are dealing with systems of oppression that are patterned, well-practiced, and create similar adverse outcomes across large numbers of

people, we can also see how intersectionality and the compounded impacts of multiple forms of oppression affect entire populations of people. Achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustices, and providing resources according to need.[4] In a racially equitable society, the distribution of society's benefits and burdens would not be skewed by one's race. Racial equity holds society to a higher standard; it demands that we pay attention not just to individual-level discrimination, but to overall inequities across social and health outcomes.[9] Adopting an equity lens into IVP strategies provides a framework to address confounding factors, allocate resources, and ensure accessibility according to the specific needs of individuals and communities at the greatest risk of experiencing intentional and unintentional injuries.[10] Furthermore, addressing racial and health equity in IVP based on the **Truth, Racial Healing, & Transformation pillars** provides a framework for informing community-led action, improving health outcomes for all members of society, and eradicating structural inequities.

Findings from the **Safe States IVP Health Equity Scan** suggest that to effectively incorporate equity into IVP programs, practitioners must be able to:

- **Use longitudinal data to identify vulnerable and subpopulations adversely impacted** by the topic of concern;
- **Develop community-level partnerships** to understand the historical context of the subpopulation better; and
- **Implement culturally-responsive programs and direct resources** within the communities of interest.

THE CORE COMPONENTS SUMMARIZED

Based on foundational work completed by Safe States, the fundamental elements that define the capacity of a model, state-level IVP program are the "core components." The core components reflect the evolution of state IVP programs over time and embody their efforts to continually become more sustainable and effective. With nearly two decades of data and experience to draw upon since the core components were first created, Safe States has elevated six of the core components as essential for an effective state IVP program:

CORE COMPONENT 1

BUILD & SUSTAIN A SOLID, EQUITABLE, AND STABLE INFRASTRUCTURE

Whether a state IVP program is small or large, relatively new, or well-established, it requires:

- A stable and supportive organizational home;
- Core staff that includes a director, an injury epidemiologist, and program staff for program planning and implementation, evaluation, partnership, and coalition building, policy work, training and technical assistance, and communications;
- Diverse and innovative leaders who can identify and make the most of complex challenges and opportunities, despite an atmosphere of lean resources and support;
- Planning capacity and visibility that gives injury and violence prevention programs a place at the table when funding and other decisions are made; and
- Funding drawn from multiple sources and commensurate with the size of the problem.

CORE COMPONENT 2

EQUITABLY COLLECT, ANALYZE, AND DISSEMINATE INJURY AND VIOLENCE DATA

The very foundation of public health decision-making is data. Like other public health entities, IVP programs have always been data driven. Data systems are constantly evolving, as capacity, infrastructure, and availability change. There are some gaps in data collection and analysis infrastructure, some which stem from inequitable practices; there needs to be more intentionality and population-specificity in collection efforts. The risk and protective factors that are associated with negative or positive health outcomes, driving injuries, as well as the injury outcomes, are varied, meaning that data from multiple sources can provide a complete picture and highlight particular communities of burden or underlying systemic causes. To better serve underrepresented populations and enhance diverse prevention efforts, an emphasis should be placed on prioritizing data and linkages missing from current data systems. Data dissemination should be informed by communities to ensure relevancy and usefulness.

THE CORE COMPONENTS SUMMARIZED

CORE COMPONENT 3

SELECT, IMPLEMENT, AND EVALUATE EFFECTIVE PROGRAM AND EQUITABLE POLICY STRATEGIES

Most IVP interventions use a combination of strategies including education and individual behavior change, as well as policies which aim to change environments, influence population-level behavior change, and make safer choices easier and more routine. Whether an intervention veers more toward the programmatic or the policy realm — or straddles both — it should: address a root cause of the issue, have evidence behind it, fit with desired outcomes and community characteristics; acknowledge marginalized communities with historical and racial injustices and disparities; consider both risk and protective factors; and be evaluated to determine if it worked as intended.

CORE COMPONENT 4

ENGAGE DIVERSE PARTNERS FOR COLLABORATION

The scope of injury topics and functions is so broad that no program — no matter how large or well established — can or should successfully tackle them alone. IVP programs find that collaboration and coordination with partners is essential to amplify their work and achieve health impact. Often collaboration occurs through one-on-one partnerships; however, IVP programs also play an important convening role, and bring multiple partners together to work on a range of IVP issues. Partnership activities can include sharing valuable insights on the community context, data, involving partners in program planning, exchanging funds, collaborating on policy, or exchanging training and technical assistance.

Often, partnerships yield general support for shared initiatives, but they become increasingly meaningful when resources — data, funding, training, and staff — are shared or exchanged. It is not only beneficial to partner with other federal, state, or local agencies but with local community organizations and non-traditional partnerships (academic institutions, community centers, racial and health equity-based organizations, communications groups, **businesses**, etc.). That not only expands available knowledge and resources but tailors long term programmatic and policy initiatives to specific populations. These activities could better address racial and health inequities not solely on IVP-related outcomes. There is immense value to actively work with individuals with lived experiences, share resources with those community members and come from a place of humility to accept that evidence-based practices aren't enough; to best tailor public health practices is through the lens of individuals they affect.

THE CORE COMPONENTS SUMMARIZED

CORE COMPONENT 5

EFFECTIVELY COMMUNICATE CULTURALLY RESPONSIVE INFORMATION TO KEY STAKEHOLDERS

Translating the implications and nuances of IVP data into action is a stubbornly tough sell. As IVP programs become more and more lean and are forced to function with staffing shortages for core functions such as epidemiology and evaluation, it is understandable that these programs may lack other skills, such as communications expertise. Nevertheless, communication skills – from using infographics to conducting media advocacy – are essential to effectively reach key audiences, including policy makers, partners, and focus populations such as historically disenfranchised communities. In addition to clear, consistent, and accurate communication, it is also important to frame messages and develop common language that is easily digestible, culturally competent, and articulated in a way that resonates with the intended audience. Whenever possible, key messages should be developed in conjunction with community partners to ensure effectiveness. It may be beneficial to hire communications experts to handle publications, advertisements, or press releases to ensure tone, messaging, cultural inclusion, accessibility, and mindfulness are relayed.

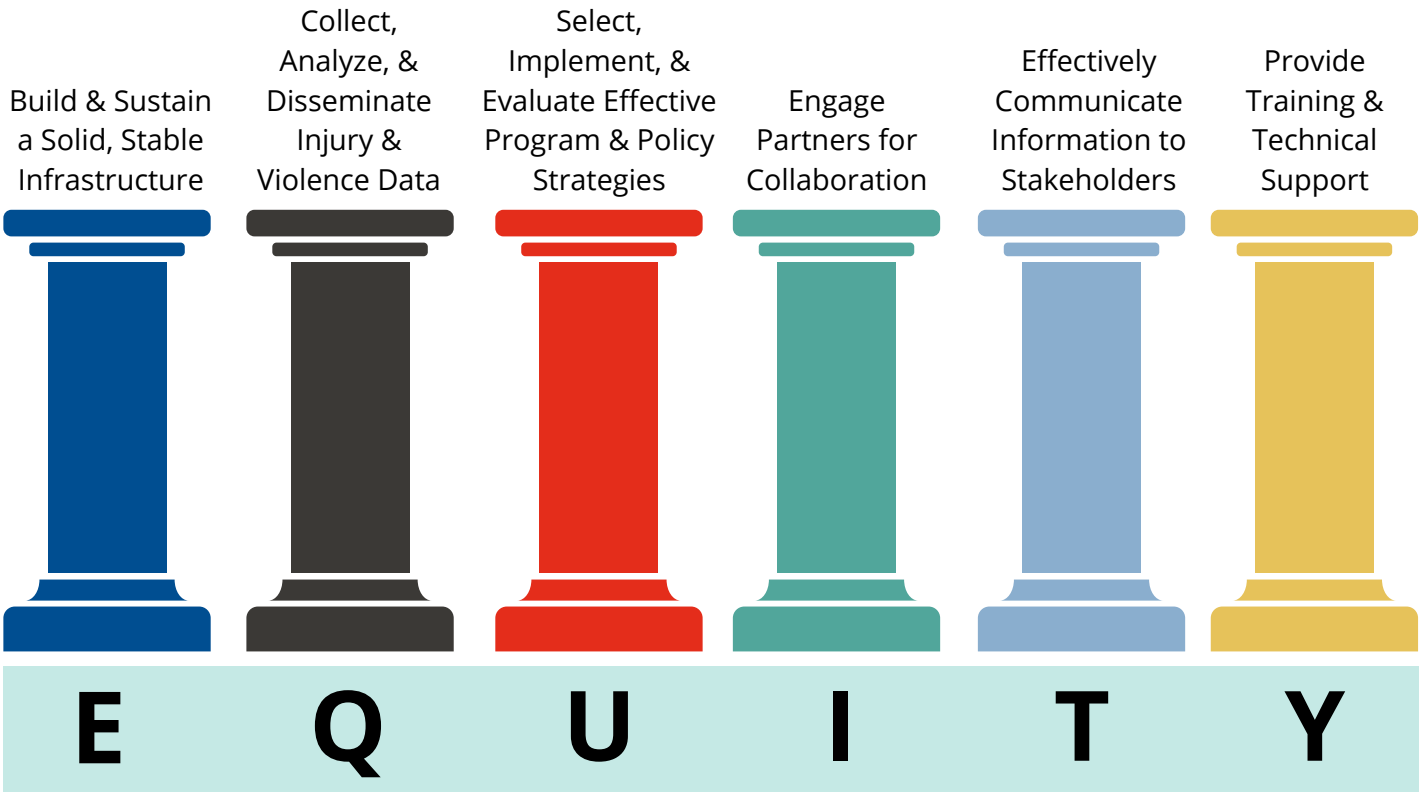
CORE COMPONENT 6

PROVIDE HEALTH EQUITY TRAINING AND TECHNICAL ASSISTANCE

IVP programs face a dual training and technical assistance challenge: keeping their own skills and knowledge current, while also sharing their expertise with partners and other stakeholders (such as colleagues in local health departments, fire departments, hospitals, and other community settings). IVP programs should identify or provide training and technical assistance for their staff and partners founded on the **Core Competencies for Injury and Violence Prevention.** Training should include skill building around DEI principles, communications, and the technical skills encompassed in the IVP Core Competencies. If capacity or expertise is a barrier, contracting with a consultant or attending other organizations' training can serve as alternative mechanisms for professional development. To ensure a baseline level of competency across staff, all team members should receive a standard set of foundational training before being encouraged to tailor additional professional development efforts to their specific needs.

THE IVP CORE COMPONENTS

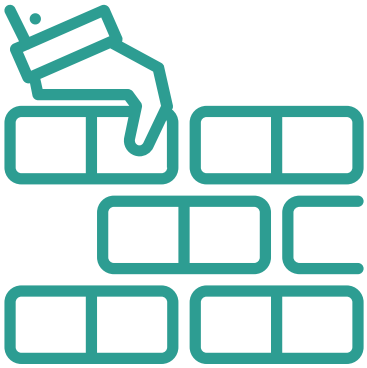
Equity must be the foundation of the essential IVP components. A successful IVP is one ensures all support, resources and opportunities are fairly distributed.



WEAVING EQUITY ACROSS THE CORE COMPONENTS

The Center for Global Inclusion's Global Diversity, Equity and Inclusion Benchmarks states that equity should be embedded in the organizational culture as a core value, source of innovation, and means of sustainability and success.[11] Weaving equity across the core components means that the organization is taking a proactive approach to addressing inequities and sees the organization as a microcosm of the society in which it operates.

BUILD AND SUSTAIN A SOLID, EQUITABLE, AND STABLE INFRASTRUCTURE



The 2013 *Building Safer States* resource explains that any state IVP program - whether small or large, relatively new, or long established – must include the following basic building blocks to function effectively:

- A stable, supportive, inclusive, and physically accessible **organizational home**;
- **Core staff** that includes a director, an injury epidemiologist, and program staff capable of program planning and implementation, evaluation, partnership and coalition building, policy work, training, and technical assistance, and communications;
- **Diverse leadership** who can identify and make the most of complex challenges and opportunities despite an atmosphere of lean resources and support;
- **Planning capacity** and visibility that give IVP programs a place at the table when funding and other decisions are made; and
- **Stable funding** drawn from multiple sources and commensurate with the size of the problem.

Diverse Workforce

As IVP programs work to enhance health equity in their work and populations of focus, it would be beneficial for them to consider the composition of their workforce. Dimensions of diversity include but are not limited to race, ethnicity, gender identity, country of origin, physical and mental ability, and primary language. The leadership and workforce of an IVP program should ideally reflect the communities they serve, whether through identities, lived experience, and/or perspectives. A diverse workforce brings a variety of experiences and perspectives that can be used to create innovative solutions to address health inequities in marginalized populations. In addition, a diverse workforce could assist with building trust with a community because of visible representation. To build a diverse workforce, IVP programs will need to improve recruitment and hiring practices to be more inclusive and equitable to attract a more diverse candidate pool. Intentional efforts should be made to ensure an inclusive, safe, and supportive work environment to foster the exchange of ideas, perspectives, and sense of belonging. Specific actionable hiring practice strategies can be found in the "Strategies to Build Health Equity into IVP Program Infrastructure" section below.

CORE COMPONENT 1:

Build and Sustain a Solid, Equitable, and Stable Infrastructure

Equity-Focused Leadership

What are the hallmarks of a well-led program? An effective state IVP program director that prioritizes equity within their staff, partners, and programs:

- Ensures all program staff feel valued and respected, all ideas are considered, and that work responsibility and pay are fair and equal across employee demographics, experiences, and education.
- Leads by example and is transparent and honest with staff and partners when mistakes are made to promote shared learning and accountability.
- Strengthens, and sustains meaningful collaborative relationships with organizations and communities that are being served. These relationships should be built on mutual respect, humility, and cultural competency. Mechanisms such as Memoranda of Agreement should be established to secure relationships long term no matter personnel changes.
- Intentionally hires diverse staff (racial, religious, differently abled, academic, and professional background), requires DEI and health equity training and work practices, leaves space for innovative thoughts, and offers professional development.
- Makes the most of national resources and linkages by participating in professional associations and networks, and engaging funding agencies and academic institutions.

The Center for Global Inclusion's Global Diversity, Equity, and Inclusion Benchmarks is a useful tool for assessing your organization's current state of DEI, determining strategy, and measuring progress. Benchmarks are organized into 15 categories across four groups: Foundation, Internal, Bridging, and External. Foundational subcategories include vision, leadership and accountability, and DEI structure and implementation. The key actions include:[11]

- Develop a strong rationale or DEI vision, mission, and strategy and align it to organizational goals.
- Hold leaders accountable for implementing the organization's DEI vision, setting goals, achieving results, and being role models. Leaders are seen as change agents and able to inspire others to take responsibility and work within their sphere of influence to advance equity.
- Provide visible, dedicated support and structure with authority and budget to effectively implement DEI. Equity-focused leadership means that equity is intentionally embedded throughout structures, policies, strategies, and practices.

Funding

Investments in preventing injuries and violence, especially long-term within marginalized communities fall short compared to the costs associated with these events. The funding challenges faced by state IVP programs are numerous and state IVP programs must piece together the few resources that are available through small grants from many different funding sources. To contend with ongoing funding challenges, state IVP programs can:

Cultivate relationships and partnerships that can lead to funding support (e.g., transportation, housing, pedestrian safety, law enforcement, academia, mental health, substance use, anti-racism, health equity, etc.)— even if the pay-off does not occur for many years. In Michigan, a reproductive justice and sexual violence prevention organization, MOASH, established a youth led advisory council to advocate for sexual violence prevention. This council, ran by Black, Indigenous, and People of Color (BIPOC) youth partnered with organizations like Planned Parenthood, the Department of Human and Health Services, and Comma Bookstore and Social Hub to organize digital summits, workshops, and a Hill Day. Even though the partnership is new, it is strong and well-institutionalized, MOASH has already received funding for next year to continue sexual violence prevention education and activities throughout the state.

Explore reimbursable funding streams from payers, such as Medicare for older adult falls prevention or Medicaid for IVP efforts focused on low-income children and youth. For example, Alaska's IVP program analyzed trauma registry data to determine causes of injury among Medicaid patients and the costs associated with these injuries. A Memorandum of Agreement with the state Medicaid agency supported technical assistance and training, programs to prevent common injuries, tools, and resources for partners (e.g., "Injury Prevention in a Bag" — a home safety education kit for home visiting staff that included a room-by-room safety checklist). These services will mostly support low-income individuals, new mothers, and differently abled persons; providing them with information that they may not have received due to lack of resources and education and it can combat potentially hazardous practices that could be culturally normative. This program also provides support for surveillance and data analysis activities related to the state's trauma registry, and linkages to the Medicaid Management Information System.

Funding - Continued

Consider alternative, flexible funding sources such as local foundations. Local foundations are typically deeply invested in the community and are interested in innovative solutions. Foundation funding may be able to jump-start ideas more quickly than other traditional funding sources. With careful planning, foundation funding can be used to leverage government dollars and ensure long-term sustainability of a program, as was the case with Richmond and Henrico County Health Districts, where they successfully implemented a continuous funding cycle using philanthropy and government dollars to fund innovative programs.

Integrate program implementation and funding with other public health programs — such as chronic disease prevention or maternal and child health. In 2018, the Institute for Public Health partnered with research universities and hospitals in the St. Louis, Missouri area to launch the "Life Outside of Violence" program. After assault victims (i.e., gunshot, stabbings, etc.) have been discharged by a hospital, a case manager works with each victim and their family to develop plans to stay safe, connect with community resources, continue treatment, and stay supported.

Redirect fees and fines — States have worked with advocacy groups and state legislators to earmark a portion of collected fees and fines to support both state and local IVP programs. For example, Alaska receives over two million dollars monthly in cannabis sales. The marijuana tax is then divided into three funds: 50% in a recidivism reduction fund, 25% in marijuana education and treatment fund, and 25% in a general fund.[12]

Increasing Knowledge and Organizational Capacity

State IVP programs should be able to work cross-culturally as they address IVP issues in various populations. Developing a workforce committed to health equity will require the implementation of continuous training to provide culturally appropriate IVP interventions. As IVP professionals work in the field, it is important they have baseline knowledge and skillset to understand populations' experiences and culture and to build genuine and respectful relationships with community members. Implementing training sessions that include specific, realistic, and honest examples on the prevalence, relevancy, and result of oppression and power, racism, and cultural humility would be useful to develop these skills in staff members. Strengthening partner capacity to apply a public health approach is also important in sustaining IVP programs long-term.

Strategies to Build Health Equity into IVP Program Infrastructure

- Establish your organization's commitment to advancing health equity internally and externally in mission statements and/or strategic plans.
- Establish an accountability process for implementing equity plans, vision, and/or goals.
- Implement ongoing education and/or discussions about health inequities and their causes (power structures, white supremacy and normality, oppression, etc.).
- Implement yearly cultural humility and bias training as part of performance evaluations.
- Implement training that focuses on the implementation of anti-racist strategies across IVP initiatives.
- Allocate resources and staff to implement equity-focused policies and practices, including data disaggregation.
- Ensure an inclusive and respectful environment for staff members' perspectives and experiences.
- Increase partner involvement in program implementation while the state IVP programs take on roles of promotion, facilitation, and support for both program implementation and evaluation. Sharing these responsibilities would also allow state IVP programs to build capacity and buy-in among their partners.
- Expand partnerships and share decision-making with local communities of focus. Center community voices and incorporate their lived experiences that provide insight into needs, preferred methods of communication, and any elaboration on previous unintended consequences that occurred.
- Create and maintain leadership training, professional development, and hiring practices that ensure a positive, diverse, equitable, and inclusive environment; hiring external experts coupled with lived experience should be highly considered.
- Establish leadership opportunities for Black, Indigenous, and People of Color (BIPOC), those who identify as LGBTQIA+, neuro-divergent, disabled persons, and those with diverse educational backgrounds including non-traditional educational experiences.

EQUITABLY COLLECT, ANALYZE, AND DISSEMINATE INJURY AND VIOLENCE DATA

The very foundation of public health is data. Like other public health agencies, state IVP programs have always been data-driven. Given the wide range of injury types and risk factors, multiple data sources are required to develop a comprehensive and accurate picture of injury and violence trends.

Equitable Data Collection, Analysis, and Dissemination

Currently, inequity is ingrained into how we collect and analyze data. Data that define and highlight inequities are collected or suppressed without considering historical and social contexts that impact health. This context clarifies and highlights root causes of inequities, without which key insight is missed and inequities can persist. Aggregate data, suppressed data, and the lack of data on upstream driving factors contribute to the gaps in data that make it difficult to inform equitable interventions and policies. In some cases, populations can be made invisible and/or classified as other races; for example, American Indians/American Natives are often classified as white or other.[13] It is commonplace that within federal, state, and local privacy and data collection laws, results for small populations are aggregated into others; because populations are not accurately represented it is difficult to collect, protect, and accurately use data and determine social vulnerability indexes.[13]

IVP programs should collect data on SDOHs, risk and protective factors, Adverse Childhood Experiences (ACES), and injury and violence-related health indicators by race/ethnicity, gender, sexual orientation, and/or community subgroups. Epidemiologists can provide technical expertise on data sources to query, data to collect, and the framing of surveillance methodologies to account for various sub-populations in a statistically accurate and equitable way. They should also be able to provide context around data and detail the limitations in current data being used and reported. Epidemiologists can consider alternative data sources as these might provide additional insight for communities of interest. Examples of these sources include qualitative studies, focus groups, social media, and others.

Additionally, the data should ideally reflect the different cultural foundations of the communities and populations being served. It is

essential for data collection, analysis, and dissemination methods to include community input. This exacerbates the current unequal access to data across sectors and in communities.[14] Developing population-specific data collection and sharing strategies between partners to improve access to appropriate and timely data is an important step to ensuring that data is shared with all community stakeholders in an equitable and responsive way. Finally, to improve access to community members, IVP programs should consider how the data is presented and communicated so that key points are clear and understandable to a wide variety of audiences.

Understanding how to measure success is a key strategy in advancing equity. Many communities are turning to frameworks such as **Results-Based Accountability** (RBA)[15] to identify the best available data, develop a shared understanding of the data with community partners, and identify strategies that can address the root issues. Within the RBA's step-by-step Turn the Curve process, indicators are selected based on how well it communicates to a broad audience (Communication Power), whether it is a good proxy for other indicators (Proxy Power), and whether the data is consistent and reliable (Data Power).

Data Strategies to Build Health Equity

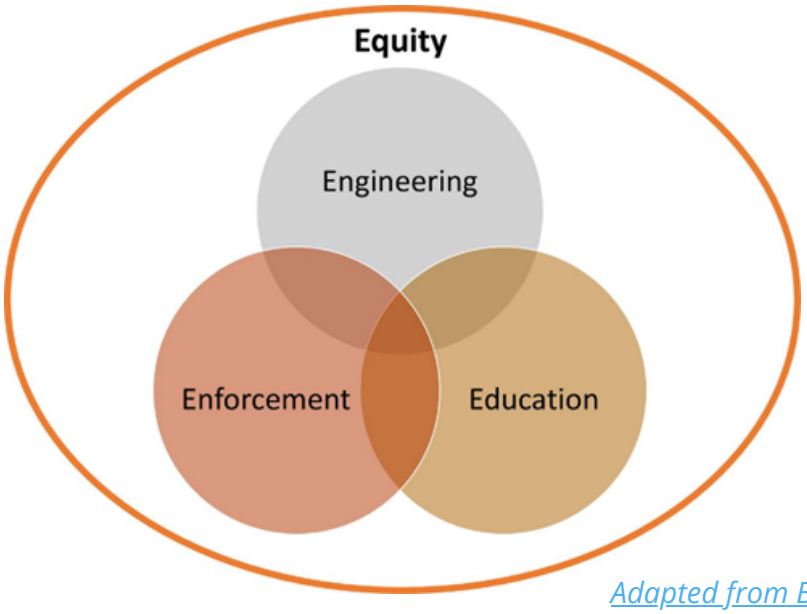
- Facilitate conversations with key stakeholders and partners about the intended result and best indicator(s) for measuring progress. Consider following a framework such as RBA.
- Encourage and provide resources for disaggregated data collection and analysis of marginalized and underserved populations to better understand the distribution of risk factors, protective factors, and overall IVP burden.
- Encourage interpreting factors such as socioeconomic status and race as relational factors as opposed to individual characteristics (as appropriate).
- Use community-based participatory research and qualitative methods to supplement quantitative data and share populations' lived experiences.
- Identify limitations and biases of data collection and analysis methods.
- Increase data and surveillance efforts to minimize inequity gaps when collecting population-level data to support research and strategy implementation.
- Discuss the root causes of IVP-related injuries and fatalities in research activities.
- Examine inclusion and exclusion criteria for data sets, and critically assess if those criteria add bias to the data.
- Include input from persons with lived experiences when developing programs and conducting evaluations.
- Be mindful throughout and include the target population in evaluation and/or planning to minimize or avoid any unintended implications from data collection, analysis, or dissemination that could produce any harmful health or cultural effects or create mistrust in a community.
- Identify potential partners who can help with data access and/or analysis.
- Identify any outside dashboards that you could merge with your own to create data automation and projections (ex. HHS Protect collecting hospital data and downloading it to their own data sets).
- Use the **data equity framework** as a guide when planning data collection efforts.
- Share dissemination timeline and process for requesting data.
- When possible, share data that can depict trends over 3-5 years to allow for more meaningful discussions about causes and solutions.

SELECT, IMPLEMENT, AND EVALUATE EFFECTIVE AND EQUITABLE POLICY AND PROGRAM STRATEGIES

Program and Policy Interventions: Comprehensive Approaches to Reduce Injuries and Violence

Dr. William Haddon, Jr., the first director of the National Highway Traffic Safety Administration (NHTSA), is credited with launching the modern field of injury prevention in the 1960s. In the decades since the Haddon Matrix was introduced, researchers and practitioners have used the matrix to analyze how programs and policies can intervene to prevent injuries. Dr. Haddon's comprehensive approach is reflected in the "three Es" of injury prevention: environment, education, and enforcement. For example, dramatic reductions in motor vehicle crash fatalities and injuries are the result of many prevention strategies at work simultaneously: safer cars and roads (the environment), individual use of seat belts and avoidance of drunk driving (education leading to changes in behaviors and social norms), and enforcement of motor vehicle safety laws (such as primary belt laws and DUI citations) that discourage these behaviors. However, the current "Three E's" approach does not consider the factors that cause injury and violence to disproportionately affect certain populations. By incorporating equity as the "Fourth E", social determinants of health (SDOH) can be addressed to decrease the severity and likelihood of injury and violence in an entire community.

Figure 1. Equity as the Fourth "E" in the Three "E's" Approach to Injury Prevention



Adapted from Bauer and Mee

CORE COMPONENT 3

With equity integrated into the Three "E's" approach, IVP programs using the framework would acknowledge SDOHs such as social contexts, education and literacy, and income as they develop and implement interventions that are appropriately tailored to the community. For example, in an economically marginalized community, equity could be incorporated into an intervention by providing appropriate low-cost child safety seats (CSS) and free CSS installation classes and inspections to all community members.

To ensure that interventions are strategically selected to achieve equitable outcomes, several frameworks can be utilized, several of which are highlighted below.

As seen in Figure 3, the Substance Abuse and Mental Health Services Administration's **Strategic Prevention Framework** consists of five steps: Assessment, Capacity, Planning, Implementation, and Evaluation. Assessment is the process of gathering and analyzing information regarding needs and resources to gain an understanding of the scope and context of the problem. Quantitative and qualitative methods, archival statistics, and first-hand anecdotal data from local sources should be included. Capacity needs to be developed to carry out a comprehensive community plan to address the local conditions and root causes for that need. Planning is the process of developing comprehensive, logical, data-driven plans, using current capacity to target conditions identified through the assessment phase. Implementation includes best practices that fit the community but stays true to the research basis of the intervention. Lastly, evaluation gives further opportunity for organizations to improve their work, coordinate more effectively, and be accountable to participants, funders, and the community.

Figure 2. Strategic Prevention Framework Model

Adapted by Strategic Prevention Framework

CORE COMPONENT 3:
Select, Implement, and Evaluate Effective and Equitable Policy and Program Strategies

The R4P Framework uses intersectionality to acknowledge the relationship of race-related stress with other forms of oppression (e.g., sexism) to understand health inequities among African Americans.[16,17] While R4P was created using the historical and current experiences of African Americans, it can be applied when working with other populations.[19] The five components are Remove, Repair, Remediate, Restructure, and Provide:

- **Remove** involves identifying and removing structures, attitudes, and practices that could cause the population to be disadvantaged.
- **Repair** refers to acknowledging and addressing historical exposures that have a current impact on the population's ability to access healthcare or to maintain healthy lifestyle practices.
- **Remediate** focuses on recognizing and addressing current exposures to reduce risk.
- **Restructure** determines how to address any institutional exposures that could impact the population in the future.
- **Provide** involves the implementation of culturally and economically feasible interventions that address the intersecting axes of disadvantage faced by the population.

The table on the next page provides guidance on how to use each component of the R4P when planning an intervention.

Table 1. Recommendations on How to Assess Each Component of R4P

DOMAIN		LINES OF INQUIRY FOR ASSESSMENT
REMOVE	*Identify **structures, attitudes, beliefs, practices, or experiences** specific to "race/ethnicity", low SES or gender that confer disadvantage to these populations*	May overlap with Repair, Restructure, and Remediate—**but** relate SPECIFICALLY to racism, gender, and income disadvantage. Looking specifically at these prevents evaluator from "cherry-picking" and/or from succumbing to personal discomfort of dealing with racism, class, and race issues. These interventions focus on change in the institution itself and may also focus on personal assessment of where the individual confers implicit privilege or bias based on ethnicity/race, SES or gender.
REPAIR	*Assess **experiences, attitudes, behaviors, and beliefs of disparity populations** about the institution that have roots in the past, and may have bearing on willingness of or ability to engage with institution*	What are some examples of historical legacy, occurrences that negatively impact on knowledge, attitudes, beliefs, practices; historical trauma, legacy of privilege or discrimination? These interventions focus on reparation of damage, public relations, marketing, improved engagement.
REMEDIATE	*Assess needs for **protection of individuals in disparate populations** against existing insults, protections that need to be in place until the insult can be structurally removed*	What conditions in the organization do disparate populations need to be buffered from/protected from, until restructuring occurs, and the insult is no longer there? These actions usually focus on changing something in the individual.
RESTRUCTURE	*Assess **structures in the organization that maintain systematic exclusion of disparate populations** (Source of "insults"; structures that continue to create risk for some populations)*	What are some structures (policy, procedures, rules, regulations, traditions, physical environment, resources, etc.) that continue to systematically exclude, hold back, or privilege some over others? This could relate to admissions, retention, course selection, course content, etc. These interventions focus on change in the institution itself.
PROVIDE	*Focus on **HOW services of the organization are IMPLEMENTED from a qualitative standpoint**. Culturally and economically feasible delivery that accommodates all gender roles and responsibilities, along with providing the required resources and environmental supports, so that it is the easiest option for people to choose and take advantage of to achieve equity*	How can ethnicity/racism, class, gender be better considered in services delivered by the institution?

Table adapted from Hogan, Rowley, Baker White, and Faustin[18]

Select, Implement, and Evaluate Effective and Equitable Policy and Program Strategies

Though not specifically equity-based, Results-Based Accountability (RBA) can be used in conjunction with other frameworks to provide a clear, structured way of moving from talking about disparities to addressing them. A key strength of RBA is the root cause analysis in which diverse stakeholders come together to discuss the underlying causes for a particular data trend (positive or negative). This is known as the "story behind the curve" and provides a strong rationale for selecting a particular program or intervention. These frameworks are clear examples of how to model IVP programs on a community or societal level using a health equity lens. Commonalities include understanding the role of social determinants of health, acknowledging the drastic inequities between affected groups and privileged populations, and better identifying the widening impact those approaches can have on affected groups. To minimize racial and health gaps, it is important and most effective to tailor interventions to the needs of specific communities and their unique contexts.

Policy Strategies

Passing legislation or changing a regulatory or organizational policy is only the beginning. Successful policy changes require educational efforts to support those impacted by the policy, as well as follow-up and enforcement during the years and decades that follow. Enforcing laws, ensuring they are appropriately implemented, investing the time and effort to evaluate them, and ensuring they are not retrenched or repealed in the future, are all part of the longer-term work required after a policy change is successfully enacted.

Policy is a major influencer in creating and intensifying health inequities in various populations through intentional and unintentional mechanisms (e.g., redlining, reducing access to transportation options, etc.). However, policy actions can eliminate health inequities, as well. Evaluating policy is essential to identify and examine policy factors that worsen health inequities or fail to eliminate them. Policy evaluation is key to proving the necessity for equitable policy reform and studying the implementation and impact of enacted policies.

The Transdisciplinary Collaborative Center for Health Disparities Research at Morehouse School of Medicine has a policy evaluation approach to examine and inform policy in terms of health equity. Included in this approach is the identification of policy dilemmas where:[19]

1. No policies existed to specifically address the health disparities;
2. Policies were adopted but poorly or inequitably implemented;
3. Implementation of existing policies resulted in deleterious consequences for vulnerable populations; or
4. Existing policies were not sufficiently evaluated to determine differential impacts among vulnerable populations.

These considerations are useful to keep in mind as IVP practitioners evaluate policies in their states to address IVP concerns using a health equity lens. Using this approach, the policy can be analyzed to identify the health issue and specific populations affected, impacts and opportunities for improvement and develop strategies in collaboration with key stakeholders, measure outcomes, and disseminate policy. As with programming, it is important that policy interventions consider vulnerable communities and their needs to truly be effective.

The Role of Evidence

Each day, programmatic and policy interventions are being developed, tested, and vetted by researchers and practitioners alike. State IVP program staff must choose among these interventions and select ones they feel are both likely to be effective and contextually appropriate for the communities involved.

These interventions must also be implemented with fidelity and on a scale that will provide the desired impact.

According to the CDC, evidence-based decision-making requires three complementary forms of evidence to determine whether a prevention program, practice, or policy can achieve its intended outcomes:[20]

1. Best available research evidence
2. Contextual evidence
3. Experiential evidence
4. Evidence Based Decision-Making

IVP program staff can use these four forms of evidence to make decisions about which programs or policies to implement, ensuring they are grounded in research evidence and informed by contextual and experiential evidence from the field.

Practice-Based Evidence to Support Health Equity Approaches

Another concept to complement evidence-based practice is practice-based evidence. Practice-based evidence refers to learning as much as we can about the real-world application of evidence-based practices — not just how a program works in a pilot or ideal situation, but how a program works in reality. Instead of treating departures from a model program as threats to fidelity or rigor, a practice-based evidence approach would incorporate the experiences of those who use and implement a program as part of the evidence base. To best implement a program with health equity ingrained throughout, professionals need to truly incorporate the thoughts, ideas, and feelings of those that live within that community. Before implementation, focus groups are needed to discuss the community's wants, needs, current resources, the continuation of that intervention post-grant cycle, and the priorities of community members. Focus groups should also be used to deepen the understanding of root causes of the issue and identify the appropriate intervention to address a root cause. The community can also provide insights about what has been tried before, what has worked, similar efforts taking place, etc. Decisions about which programs or policies to implement should not be made in haste, but should be carefully decided based on the community's knowledge, values, and context.

The Role of Evaluation

Evaluation – the systematic determination of merit, worth, or significance[19] – is essential to determine the effectiveness of any program or policy intervention. While the importance of evaluation is undeniable, state IVP programs face many challenges to evaluating interventions, including insufficient resources to complete a robust evaluation, limited staff capacity, and a lack of internal evaluation expertise and support. These challenges can also be compounded by unrealistic expectations from funders who want to see substantial health impacts within short grant cycles.

Not surprisingly, the capacity to undertake evaluation activities has positive impacts on other aspects of IVP work. Evaluation plans vary across topic areas and even if some states didn't have a formal evaluation plan, they still conducted evaluation activities.

Evaluation is an important activity that has exceptional benefits and requires thoughtful and detailed planning. When developing an evaluation plan, it is important to have inclusivity and equity embedded throughout. Questions to consider:

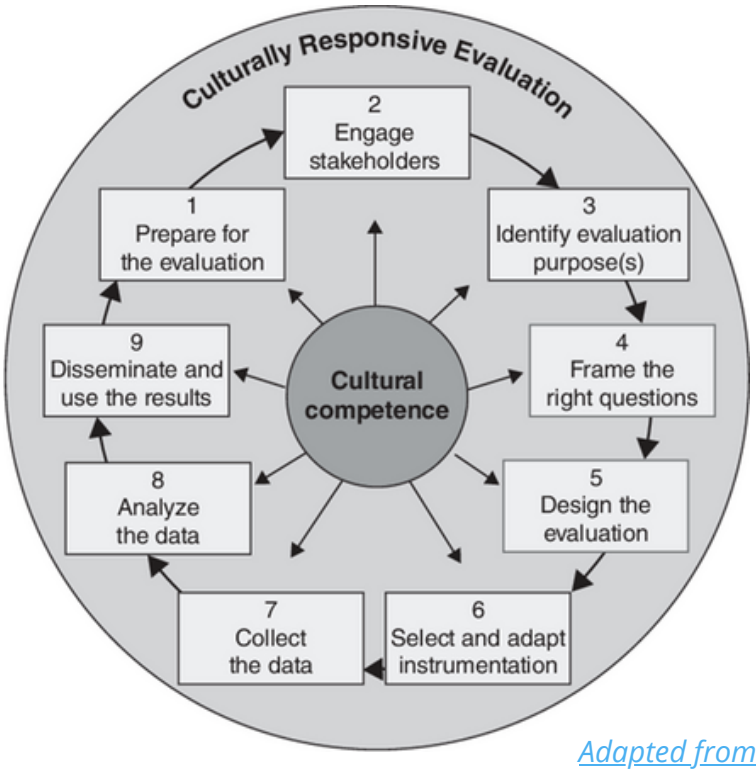
- Is the evaluation team diverse? If not, is there a plan in place to involve the community in evaluation efforts?
- Are our methods culturally appropriate?
- Does the design reveal structural causes of inequity? Is the community of focus involved and their concerns being prioritized?

- Can the evaluation data be used by participants in a meaningful way? Can we use the information we have collected to help community members achieve their goals?
- Is there a method for compensating community members for their input?

The **Culturally Responsive Evaluation Framework** acknowledges that culturally defined values and beliefs are centered in any evaluation process. It is important while evaluating IVP interventions to focus on the cultural context of the community throughout the entire process. The following actions are necessary to conduct a culturally responsive evaluation:

- Assess cultural self-awareness. Reflect on biases, assumptions, and beliefs about the community and evaluation process.
- Ensure participation by community members that are directly impacted by the program.
- Involve community members that are typically overlooked or excluded throughout the evaluation process.
- Develop a trusting and respectful environment for stakeholders.
- Validate data instruments to be used in culturally specific contexts.
- Ensure evaluation questions reflect stakeholders' values.

Figure 3. Culturally Responsive Evaluation Framework



Adapted from Hood, Hopson, and Kirkhart

ENGAGE DIVERSE PARTNERS FOR COLLABORATION

The scope of injury and violence topics and functions are so broad that no program — no matter how large or well established — can or should successfully tackle them alone. Collaborating with both internal and external partners is essential for IVP programs to achieve their outcomes and amplify their work. In addition to serving as key partners, state IVP programs also serve as conveners, bringing multiple partners together to work on a range of injury and violence-related issues.

Partnerships bolster the overall capacity and effectiveness of IVP programs. The value of partnerships is not only in their ability to expand the reach and impact of IVP programs, but also in the mutual benefits that could occur for both partners – such as the ability to share data, provide or receive training, reach key populations, or collaborate on policy efforts.

While each state and the nature of its partnerships are unique, common traditional partnerships include many of the following:

- Other departments within the state health department: e.g., *vital statistics, maternal and child health, epidemiology, emergency medical services, and health promotion/education/community health.*
- Across other state agencies: e.g., *departments of transportation, criminal justice/law enforcement, elder affairs/aging, and higher education.*
- With non-governmental organizations: e.g., *coalitions, community-based organizations, and academic institutions.*
- Federal agencies: e.g., *Centers for Disease Control and Prevention (CDC), the National Highway Traffic Safety Administration (NHTSA), Health Resources and Services Administration (HRSA), and Substance Abuse and Mental Health Services Administration (SAMHSA).*
- *Local health departments*.

Collaborating with Community Partners

Collaborations with non-traditional partners such as housing complexes, school districts, faith-based organizations, organizations serving LGBTQIA+ people, those serving individuals of cultural and ethnic

minority descent, and parent associations add significant value and key community perspectives.

These relationships provide opportunities to center community members' experiences and build the community's capacity; interventions would be more relevant and responsive to community needs, and the community will be able to effectively integrate structural changes that lead to sustained efforts over time. Partnering with local community organizations and leaders creates the space for community members to make decisions and participate in IVP interventions that directly affect where they live, work, and play. This empowers the community while challenging power structure imbalances by building trust between practitioners and community members. The partnership can widen training and technical assistance opportunities and enhance overall community economic health through employment opportunities such as internships, fellowships, and permanent job placements, and allow community members to be established as focus group participants.

It is important to note that cultivating partnerships and relationships is a long-term strategy, requiring years of patient investment, despite scarce time and resources. Much of the work of cultivating partnerships is a matter of being at the table often and long enough to make IVP issues and programs more visible. It is also important to collaborate with organizations and leaders that have a good reputation in the community and are seen as leaders.

Ongoing partnership activities include sharing data, involving partners in program planning, resource sharing, collaborating on policy, and exchanging training and technical assistance. Often, partnerships yield general support for shared initiatives, but they become increasingly meaningful when resources — data, funding, training, and staff — are shared or exchanged.

Health Equity Strategies to Build and Sustain Community Partnerships

- Establish mutually beneficial relationships with community gatekeepers (e.g. faith-based leaders, parents, local business owners, etc.).
- Seek community participation and opinions in the planning, implementation, and evaluation of interventions.
- Be transparent with community partners about intentions and needs.
- Consider creating a community advisory board or community coalition board.
- Allocate resources to build community capacity through training, leadership development, and resource identification.
- Identify and collaborate with grassroot organizations.
- Communicate regularly with partners. Consider newsletters, quarterly meetings or calls to share updates and explore opportunities for collaboration.
- Follow up when receiving suggestions and feedback.
- Share power and decision-making. Allow partners to lead or co-lead meetings, calls, etc.

EFFECTIVELY COMMUNICATE CULTURALLY COMPONENT INFORMATION TO KEY STAKEHOLDERS

Communicating about injuries and violence – including data, prevention activities, and actions for decision makers and the public – can be challenging. However, it is crucial that IVP programs can share injury and violence information in a manner that is linguistically and culturally appropriate for their audience. Whether communications are directed to policymakers, partners, or the public, it is important to ensure that they are understandable and easily accessible to all key audiences.

Information shared with community members and other stakeholders should not reinforce ongoing oppression or perpetuate health inequities. IVP programs should be sure to avoid language and images that could reinforce stereotypes and damaging narratives of the populations of focus. The program should also focus on the root causes of injuries and violence, highlighting solutions rather than criticizing an individual or population's actions.

Equitable communication requires improving the community's access to information. The use of terminology that is culturally appropriate and understandable to the community is essential. In addition, IVP programs should consider the communication channels used to disseminate information. Public health messaging can be televised, aired on the radio, included in newspapers, and shared at schools, hospitals, and grocery stores; the more that public partners can expand the placement of information, accessibility amongst community partners will increase. Factors such as population literacy, language barriers/proficiency, and unreliable internet access, should be considered as IVP programs determine the best way to get information to the public in a timely manner.

If you are experiencing challenges or could use additional guidance regarding translation, or communicating with marginalized populations, your program's public information officer or an external consultant can be an excellent resource for additional communication expertise. Additionally, all staff should regularly attend DEI and health equity communications trainings to increase their individual capacity in this area.

Health Equity Strategies for Communication Activities

What can state IVP programs do to become more visible and more effective in communicating messages about data, interventions, returns on investment, and outcomes? They can:

Develop and document a communication plan. A communication plan can be used to detail key communication strategies and messages and the internal and external stakeholders or audiences to whom these messages are to be conveyed. The plan can include communication goals and objectives, descriptions of key audiences, communication channels that reach these audiences most effectively, and specific messages and talking points that are tailored for each key audience. By having a documented communication plan in place, a state IVP program can ensure that audiences are kept informed and engaged, and that messages are conveyed consistently and effectively. This will ensure that key points are reinforced, even when they are tailored to a variety of audiences.

Regularly communicate with key contacts. Once a communication plan is developed, it can be used to identify "essential" communication contacts among partners, local or statewide media agencies, and others who should be informed about the IVP program's work. These contacts should regularly receive updates about ongoing activities, new initiatives, recent data, and any other information that communicates the important work being accomplished by the IVP program. Likewise, if a partner makes a request for information, the request should be fulfilled as quickly as possible.

Understand Social Determinants of Health (SDOH) and respect audience priorities. Injury and violence statistics often illustrate many disparities and inequities that exist within communities, reflecting the influence of SDOH — "the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness." These circumstances are influenced by "economics, social policies, and politics."[19] It is important to understand how SDOH influences community and cultural priorities and how IVP messages can support these priorities. For instance, in neighborhoods where violence is a primary concern, messages on how to prevent community violence may initially need to be prioritized before messages about other issues (e.g., active living, bike helmets, safe sleep, etc.) are introduced.

Health Equity Strategies for Communication Activities - Continued

Translate data, intervention activities, and other information in languages relevant to the population being served (i.e., Spanish in a majority Spanish speaking community).

Use graphics, fact sheets, and/or other brief formats to disseminate information.

Use accessible channels to share information to communities (e.g., social media, blogs, organizational websites, local businesses, schools, faith centers, etc.).

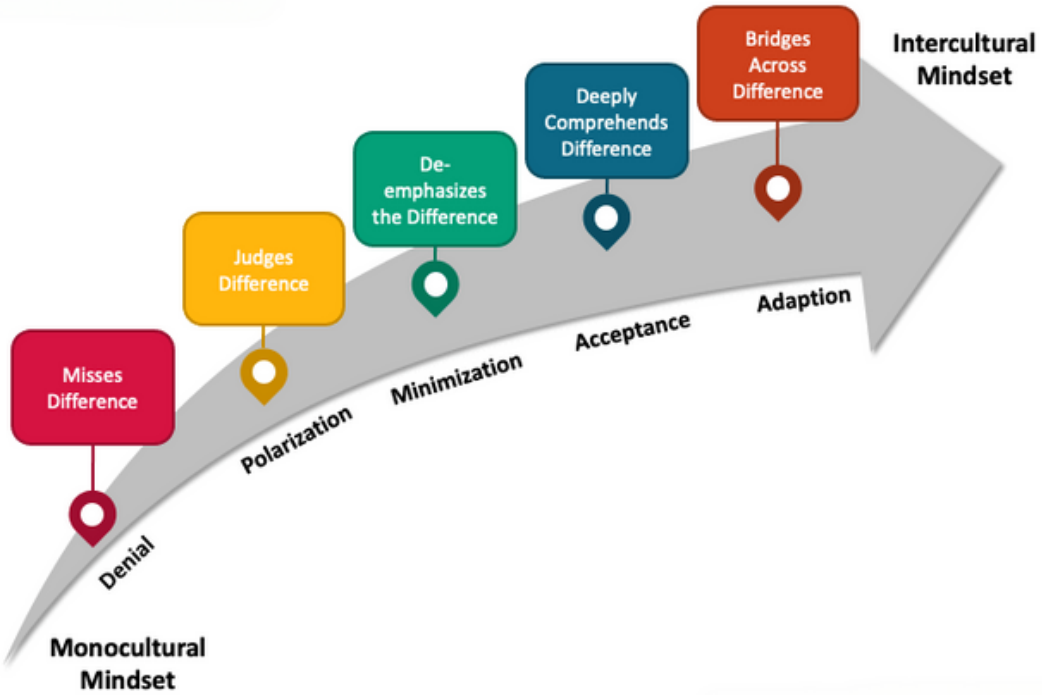
Strengthen storytelling techniques. Storytelling is a powerful and compelling communication method that can capture an audience's attention, engage them emotionally, and motivate them to act. By telling personalized stories, public health professionals can convey how complex surveillance systems and prevention programs positively impact everyday lives. Be mindful of unintended consequences storytelling can hold and shape your stories based on evidence and practice-based activities. Make sure to avoid language that demonizes marginalized populations, is intrusive, and/or doesn't focus on systemic causes for injury and violence.

Create and maintain a photo library. The most powerful element of any communication effort is always visual. Whenever possible, pictures (with permission) should be taken at every program, training, or event. Be mindful and honest of who and what is being photographed; limit photos of marginalized communities for the purpose of showing diversity. If there's a lack of diversity at events, it's time to evaluate your DEI strategy and shift target marketing audiences. These photos should be kept organized in a digital format and regularly included in internal and external communications. These photos will go a long way toward illustrating the work of the IVP program in a way that words and numbers alone cannot.

PROVIDE HEALTH EQUITY TRAINING AND TECHNICAL ASSISTANCE

State IVP programs face a dual training and technical assistance challenge: keeping their own skills and knowledge current, while also sharing their expertise with partners and other stakeholders (e.g., students and colleagues in local health departments). Given the wide range of topics, functions, and skills that IVP professionals must have, keeping up to date is a considerable challenge. Efforts to meet training needs can take many forms, ranging from conferences to webinars, and can include a wide variety of information, from updates on specific injury topics to skill-building in leadership, coalition building, communications, evaluation, DEI, or policy. A valid assessment, such as the **Intercultural Development Inventory**, can be used to measure individual staff or an organization's cross-cultural competence along a continuum. Following trainings and/or technical assistance, organizations or individuals may choose to re-take the assessment to measure progress along the continuum.

Figure 4. Intellectual Development Continuum (IDC™)



Adapted from Intercultural Development Inventory

CORE COMPONENT 6

Provide Health Equity Training and Technical Assistance

Opportunities to both receive and provide training and technical assistance, integrating training with partnership and collaboration include:

- Extend training and technical assistance to partners — especially those outside of public health. Often, partners in related but separate fields welcome an orientation to the public health approach and the emphasis on prevention and equity— particularly if it was not part of their own professional training. For example, **Ragan Communications** provides a plethora of guidebooks, resources, and can provide training geared towards DEI communication methods, culturally appropriate PR and media relations strategies, writing and editing, and etc.
- Adapt and adopt related training from others — within and outside of public health. Other public health programs (such as chronic disease programs) may feature similar approaches to evaluation, policy assessment, health equity, and coalition-building. Similarly, organizations outside of the traditional realm of public health can provide useful skills for IVP professionals. For example, the **Community Health Training Institute** provides targeted skills development to people working to build healthy communities in Massachusetts; their pieces of training surround core competencies such as coalition building, health equity, youth development, strategic planning, and evaluation.
- Partners at the local, state, and national levels can be both providers and recipients of targeted technical assistance to support shared goals and objectives.
- Provide opportunities for individuals with diverse backgrounds to experience the field first-hand. By engaging entry-level public health professionals – either through **CDC's Public Health Associate Program** (PHAP) or through other internships and fellowships for students at Historically Black Colleges and Universities, or academic programs serving those with hearing, sight, or other impairments – state IVP programs can expand their capacity to accomplish their work while drawing more talented people into the field who have direct lived experiences.
- Use training to create a "deep bench" of cross-trained staff within the state IVP program. Send staff to national meetings and conferences, participate in short-course injury and anti-racism training programs, offer different certification incentives, and diversify your new hires.

Health Equity and Anti-Racism Training and Technical Assistance Resources

- Safe States Alliance **Training Center**
- Society of Public Health Education **Health Equity Toolkit**
- SAVIR **Advocacy Training and Archived Webinars**
- Futures Without Violence **Anti-Racism as Violence Prevention**
- CDC **What is Health Equity?**
- Michigan Public Health Institute **Health Equity Training (e-Learning) – MPHI**
- Indian Health Service (IHS) **Fellowship Program**
- Centers for Disease Control and Prevention **10 Essential Public Health Services**
- PolicyLink **Featured Resources**
- Local and Regional Government Alliance on Race & Equity **Tools & Resources**
- National Center for Cultural Competence Cultural and Linguistic Competence **Policy Assessment**

CONCLUSION

As the practice of injury and violence evolves, integrating and addressing the societal structures that drive inequities in injuries and violence is critical to reflect on the imminent need for prioritizing health equity throughout all facets of an IVP Program. Mechanisms will continue to grow and change, yet the general principles will hold constant, health equity is valuable, necessary, and must form the foundation of all efforts in order to affect health and wellbeing outcomes. The fight against anti-racism and the push for intentional diversity, equity, and inclusion will vary across state IVP programs, reflecting the culture and norms of each community. State and local health departments have incorporated organizational DEI assessments, added health equity-centered professional roles, and are developing partnerships with social and racial justice organizations. With the pressures of inconsistent funding, politicized health opinions, and everchanging societal norms, it is challenging to predict how health equity practices will be embedded and prioritized long term. Thus, it is vital to formally incorporate health equity into the core components described of a model state IVP program to ensure they remain an ongoing and foundational element of all IVP efforts. In all, prioritizing the health of all populations while minding the historic and systemic causes of disparities and discrimination across different populations will require attention, advocacy, community partnership, and humility. This may be challenging and will require active listening, unlearning white supremacy normality and relearning historical accuracy, minimizing wealth and power gaps, and giving voices to those who historically haven't had one. The field of IVP has shown its resilience, growth, and dedication over decades of practice, and there is no doubt that the passionate practitioners in the field will rise to the challenge bringing opportunities, value, and action to practice anti-racism and advance health equity.

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Figure References

Figure 1. Diagram of Equity as the Fourth "E" in the Three "E's" Approach to Injury Prevention Giles, A., Bauer, M. E., & Jull, J. (2020). Equity as the fourth 'E'in the '3 E's' approach to injury prevention. *Injury prevention*, 26(1), 82-84.

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