
#SAVIR2024 Conference Presenter Guidelines to Address Health Equity and Racism



Advancing Injury Prevention
Through Community-
Engaged Research



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Conference Presenter Guidelines to Address Health Inequity and Racism

To advance the science of injury and violence prevention, SAVIR strives to build an inclusive community of scientists that encourages and celebrates diverse voices and involves authentic and empowered participation. This is a living document meant to continually improve our understanding of the prejudiced social, cultural, economic, and political inequities that exist in our society and result in large and unjust health inequities. This document is meant to provide guidelines for considering the impacts of racism on injury and violence prevention research. We understand that systemic and structural racism affect how populations are exposed to harms and shape their risks for injurious and violent health outcomes. We urge injury and violence prevention researchers and practitioners to identify racial disparities, dismantle systemic racism that results in health inequities, and promote health for all people.

Statement on Promoting Health Equity

Promoting health equity is a guiding priority and a core value of SAVIR. The basic unwavering principle of our work is that **all people have an equal right to health and safety.**

As an organization that is focused on promoting health and safety for all people, we strive to identify racial disparities, dismantle systemic racism that results in health inequities, and promote solutions to achieve just social, political, and cultural systems that improve health and wellbeing for all people.



Guidance for Conference Submissions and Presentations

We encourage the submission of abstracts from people of all backgrounds and at all stages of their careers.

Descriptive epidemiology is a substantial part of injury and violence research. As part of SAVIR's commitment to good science, we encourage presenters to be thoughtful in considering differences in injury and violence outcomes by sociodemographic factors, such as race, ethnicity, caste, religion, and country of origin, and other factors beyond race, including age, sex, gender identity, sexual orientation, ability, socioeconomic status, justice involvement, housing status, mental health, substance use, and other determinants that can lead to systemic and social stigma or discrimination. Strong scholarship examining race-based differences in health involves careful consideration of the system of exposures and social factors that shape risk. For example, if fatal car crashes are significantly more common among a specific race group, consider the social exposures that give rise to the difference. Not only is it important to evaluate if a difference exists by observable and non-observable factors (e.g., race as defined later under "Key Definitions"), but it is also important to characterize why such a difference exists. Doing so will facilitate greater understanding of the problems being described and consideration of the range of potential ways to craft solutions. Similarly, while adjusting for race, ethnicity, or other such characteristics as a confounder (a nuisance factor) in an exposure outcome relationship, it is important to understand what is really being adjusted for (e.g., race or structural racism, sex or sexism). Adjustment for these factors shows that the authors understand "who gets the outcome?" and "who gets exposed?" is affected by what they look like. An adjusted analysis thus suggests that "if there were no racism, we would see such and such associations;" which is akin to saying, "here are the results after ignoring racism." Hence, merely adjusting (as a confounder) and not reporting effect measure modification by these factors (e.g., race, gender) leads to a cover-up of the underlying structural racism or sexism. We believe that it is very important to examine effect measure modification by race and other non-modifiable and modifiable factors, and attribute them to the appropriate context (e.g., racial inequities exist due to structural racism). Further, potential mechanisms that lead to the observed disparities should be discussed, and where possible a discussion on potential interventions to address the racial disparities should follow.

On the next page are key definitions and recommended readings to further help presenters understand these issues better. Note: We have aligned and coalesced these definitions from multiple sources which are presented in the recommended readings at the end of this document. These definitions are evolving, and we will revisit them each year to align them with the most current understanding of these topics.



Key Definitions

We recognize that the incidence and prevalence of health conditions and health status varies across groups, such as by socioeconomic position, race, ethnicity, sex, gender identity, sexual orientation, nativity, ability status, geographic location, or some intersection of these identities. Higher rates of injury and violence are often observed among people in stigmatized, underserved, and under-resourced populations; differences are largely attributable to social factors, such as limited access to high-quality housing, schools, and medical care; as well as the discriminatory practices shaping these systems.

Health disparities are differences in health that are often attributable to the systematic and unjust distribution of social and structural (political, economic, environmental, and cultural) factors that support health and well-being.

Health equity is when everyone has the opportunity to attain their full health potential, and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstances. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to jobs with fair pay, quality education and housing, safe environments, and health care.

Race is a socially constructed classification based on observable characteristics (e.g., what one looks like, or sounds like, or based on origin) and was created to maintain social and political power, disenfranchise, or to subjugate groups of people. Scientific evidence unequivocally shows that race is not a biologic construct. Associations between race and health outcomes arise due to persistent social and political disadvantage among racialized groups. Hence, the population level associations between race and health outcomes are really associations between racism (particularly systemic racism) and health outcomes.

Systemic, structural, or institutionalized racism is the system of cultures, processes, policies, and values that advantage or discriminate one group of people over another and allow certain groups of people to flourish at the expense of others. Racism is manifested at all aspects of life, including education, employment, policing and criminal justice, housing, environmental exposures, income and wealth, healthcare, politics, and governance, and it is often encoded into law and policy.

Individual racism can be differentiated from systemic racism in that it is exhibited by individual people in form of discriminatory or prejudiced behavior, speech, and actions (or inactions) towards others based on their observable characteristics (e.g., race as defined above).



Recommended Readings and Resources

- Jones CP. Levels of Racism: A Theoretic Framework and a Gardner's Tale. Am J Public Health. 2000 Aug;90(8):1212-5. doi: 10.2105/ajph.90.8.1212.
- Jones CP. Invited Commentary: "Race," Racism, and the Practice of Epidemiology. Am J Epidemiol. 2001 Aug 15;154(4):299-304; discussion 305-6. doi: 10.1093/aje/154.4.299.
- Braveman PA, Kumanyika S, Fielding J, Laveist T, Borrell LN, Manderscheid R, Troutman A. Health disparities and health equity: the issue is justice. Am J Public Health. 2011 Dec;101 Suppl 1(Suppl 1):S149-55. doi: 10.2105/AJPH.2010.300062.
- American Public Health Association. Research and intervention on racism as a fundamental cause of ethnic disparities in health. Am J Public Health. 2001;91(3):515-516.
- American Public Health Association. Creating the Healthiest Nation: Advancing Health Equity.
- Ford CL, Airhihenbuwa CO. Critical Race Theory, race equity, and public health: toward antiracism praxis. Am J Public Health. 2010;100 Suppl 1:S30-S35.
- Robert Wood Johnson Foundation. What is Health Equity?
- Trent M, Dooley DG, Dougé J. The Impact of Racism on Child and Adolescent Health. Pediatrics. July 2019.
- U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008. A Resource to Help Communities Address Social Determinants of Health.
- Boyd RW, Lindo EG, Weeks LD, McLemore MR. on Racism: A New Standard For Publishing On Racial Health Inequities. Health Affairs Blog, July 2, 2020; Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20200630.939347/full/>