SAFE
K:DS
WORLDWIDE®

Equity
in Child Safety

Strategic Plan
2024 - 2026

Message from the President

We are proud to present the Safe Kids Worldwide Strategic Plan for 2024 - 2026, focused on a commitment to Equity in Child Safety. This document represents the fruits of a consistent and thoughtful effort over 18 months to rethink our approach to child injury prevention.

Since our inception in 1988, Safe Kids has worked with partners to help reduce the rate of child fatalities by 60 percent. But through it all, we have learned that to protect every child and to have the impact that every parent deserves, we must think differently. And for us, that means prioritizing our efforts on building equity in child safety.

This strategic plan will serve as our roadmap in that pursuit. We are grateful to the wide range of contributors, including partners, coalitions, and Board members, whose expertise and insight added much to our discussions and the resulting plan.

We look forward to working together with partners and top experts in the field as we take this journey to prevent more injuries, save more lives, and obtain equity in child safety.

Torine Creppy
President
Safe Kids Worldwide

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Glossary

Groups that are marginalized and underserved: People who experience discrimination of any kind and encounter barriers (e.g., racial, ethnic, gender, sexual orientation, economic, cultural, and/or linguistic) to accessing public health and health care goods and services. They thus receive fewer and lower quality preventive interventions; have a lack of familiarity with public health and safety delivery systems; face a shortage of readily available providers and lack access to quality systems of care and infrastructure.[i]

Health disparities: Differences in health outcomes between groups of people, such as rates of fatal childhood injury.[ii]

Health equity: The state in which everyone has a fair and just opportunity to attain their highest level of health.[iii]

Health inequities: Differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work, and age that contribute to health disparities.[iv]

Intersectionality: A lens for observing the way social categorizations such as race, class, and gender interact within an inequitable societal context to lead to overlapping and interdependent systems of disadvantage.[v]

Social-ecological approach: A framework that considers the complex interplay between individual, relationship, community, and societal factors.[vi]

Societal factors: Influences that affect equitable access to quality education, employment, housing, built environments, and other needs. These can include ableism, classism, racism, sexism, transphobia, homophobia, and xenophobia as well as other forms of structural discrimination.[v]

I. Safe Kids Worldwide: Equity in Child Safety

At Safe Kids, a commitment to equity in child safety is critical to achieving our mission to keep all kids safe from preventable injuries. Together with partner organizations, we have made significant progress over the past 36 years. However, to protect every child from preventable injury we must prioritize our efforts on identifying and engaging with groups that have been marginalized and underserved and are at increased risk. It is also clear that while our efforts to raise awareness and educate families need to continue, we also need to pivot to change the systems and structures that have created the inequities we see today. When we prioritize equity, every child benefits.

To meet these challenges, we are updating our mission and vision statements:

Mission

We work to reduce unintentional injuries to children ages 0-14 and build equitable and sustainable systems that support injury prevention.

Vision

We envision a world in which every child is protected from unintentional injuries.

Prioritize equity. Every child should have access to, and benefit equitably from, injury prevention strategies. As we form our priorities, we consider the systemic, historical factors that have impacted safety among groups that have been marginalized.

Our vision and mission are supported by our core values.

Lead with science. We are well positioned with our large network to take research to practice. Our efforts are data driven and based on best evidence. We focus our efforts in the areas in which we can have the highest impact on reducing deaths and serious injuries.

Be proactive. Unintentional injury patterns change over time. We look ahead and address emerging injury vulnerabilities created by new technologies and social conditions.

Cultivate collaboration. Preventing childhood unintentional injury is difficult, especially for those who are most vulnerable. We believe in meeting families and communities where they are. We believe strategic partnerships with other organizations are crucial to creating the best outcomes for kids.

Change systems. We believe in a systems approach to injury prevention. While awareness and education are important, they are not enough. We must also advocate in support of legislative, regulatory, and civil society/industrial measures to address systemic sources of child injury. We will collaborate and help coordinate efforts across the local, state, and national levels.

Foster sustainability. Critical aspects of kids' unintentional injury prevention involve changes that take multiple years to fully embed in society. We help states, communities, and families build a culture of safety through sustainable, long-term systems change.

Live our values every day. We approach our work with passion, positivity, pace, and perseverance while prioritizing impact. We pay attention to diversity and inclusion in how we build our team.

II. Strategic Framework

Based on the science, our experience, and dialogue with partners and experts, we have developed a new strategic framework:


A. **Prioritize equity and impact:** Effectively reach communities that are marginalized and underserved & expand our focus on the leading causes of fatality (traffic crashes, drownings, and unsafe sleeping environments).

B. **Gather evidence in practice:** Validate and scale interventions.

C. **Design education and awareness interventions:** Fill gaps based on evidence.

D. **Advocate for laws and policies:** Interact with lawmakers and policymakers.

E. **Sustain systems change:** Make lasting changes to consistently help communities with the greatest needs.

A. Prioritize equity and impact

We reaffirm our historical commitment to children ages 0-14, aligning with the focus of children's hospitals and health care networks. We studied several possible focus areas in terms of unmet needs and our ability to have impact. This plan is focused on four areas.

Child Passenger Safety

Groups That Are Marginalized and Underserved

Safe Sleep

Water Safety
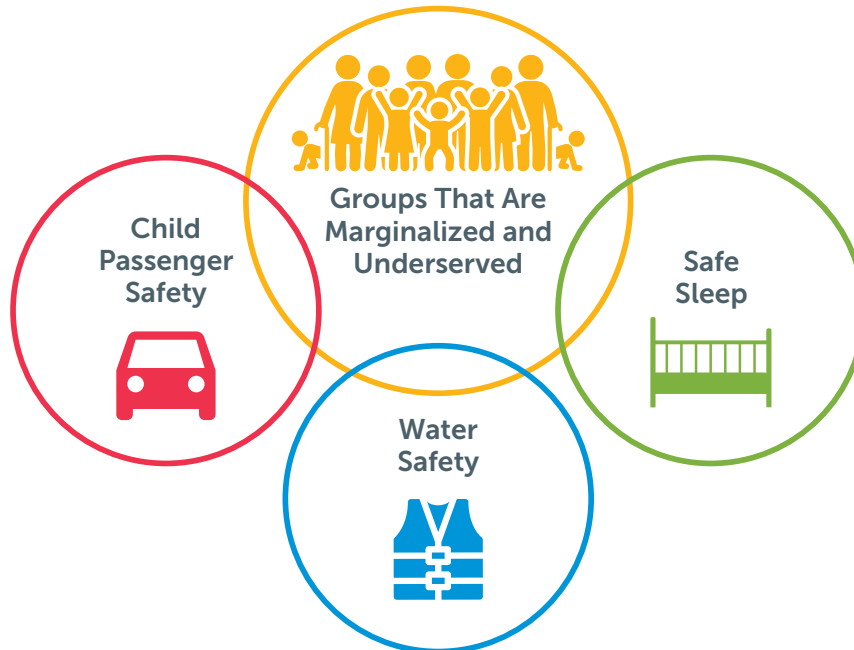
Groups that are Marginalized and Underserved

We have made strides in the last 36 years. We still have not reached all the groups who need our help. For example, among children ages 0-14 years:

- Black/African American children die from unintentional injury at 5.1 times the rate of Asian/Pacific Islander children and 1.8 times the rate of White children;

- American Indian/Alaskan Native children die from unintentional injury at 3.9 times the rate of Asian/Pacific Islander children and 1.3 times the rate of White children;

- Children in rural communities die from unintentional injury at 1.9 times the rate of children in urban communities, with risk from multiple injury mechanisms; and

- Poverty worsens each of these inequities.[vii]

The communities we work with prioritize outreach differently depending upon local needs. The intersections of different kinds of marginalization and different injury causes raise further challenges and nuances. We consider historical and contemporary patterns in shaping our priorities, considering the role of, for example, ableism, classism, homophobia, racism, sexism, transphobia, and xenophobia in inequitable injury outcomes.[v]

Water Safety Example

Drowning is the leading cause of death among children ages 1-4 years and second leading cause of fatal unintentional injury among 5–14-year-olds.[ix] While evidence-informed preventative actions exist, there are many historic and contemporary factors that differentially impact groups based on social drivers of health and result in disparities in drowning prevention. Efforts to prevent drowning need to consider groups that have been marginalized and underserved to ensure their needs are being met and that actions are not increasing inequities. For example:[v]

Injury Disparities in Context: The Example of Water Safety	Social Drivers			
	Socio-Economic Status	Disability	Immigrant Status	Race
Housing proximity to unsafe natural bodies of water; public pool location	■		■	■
Historical segregation of public pools, closure of public pools after desegregation			■	■
Swim lessons: Historical lack of access, High costs, Less availability of multilingual education or adaptive aquatics programs; Limited locations	■	■	■	■
Ease of use of life jacket, life rings if ESL (English as Second Language) or low literacy		■	■	
Cost of U.S. Coast Guard approved life jacket (>$30)	■			
CPR education: High costs, accessibility	■	■	■	

Injury Areas

In addition to a focus on groups that are marginalized and underserved, we are increasing our focus on Child Passenger Safety, Water Safety, and Safe Sleep, as they are the three leading causes of fatality under age 14. In these four areas, we will take an integrated approach across the three pillars of evidence, education, and advocacy. Beyond Water Safety, Safe Sleep, and Child Passenger Safety, Safe Kids Worldwide, its network, and partners work to keep kids safe at home, at school, at play, and on the way. We will continue to provide materials (tip sheets and fact sheets) and engagement (such as annual observances) in a variety of other injury areas, such as: ATV, bike, button batteries, carbon monoxide, choking and strangulation, falls, firearms, fire and burn, pedestrian, playgrounds, poison (laundry packets, medication, etc.), railroad, school bus, sports, TV/furniture tip-overs, toys and other emerging issues.

B. Three pillars: Evidence, education, and advocacy

Historically, our work has focused on awareness and education, and we will continue to support this pillar of injury prevention. However, both the science and our experience suggest that to substantially impact some of the persistent problems in unintentional injury, we need to place a greater emphasis on two other important pillars: evidence in practice and advocacy.

> **Gather evidence in practice**. Many injury prevention methodologies have only been tested in small trials with anecdotal evidence. Given the large Safe Kids network of community partners, we are well-positioned to help validate interventions at scale. This will help develop knowledge for the field in general. It will also help direct our funders' resources to the highest-impact projects.

> **Advocate for laws and policies.** We have had success with federal advocacy (for example, in the Virginia Graeme Baker Act and Child Passenger Safety laws). Many injury problems have root causes in the structural and/or material conditions of life facing children and families. Through our presence at the national, state, and local levels, Safe Kids is positioned to help coordinate and/or lead efforts to pass greater reforms. These efforts include reforms in consumer product and environmental regulation, effective and fair enforcement, and coordinating the cascade of resources from the national to state and state to local levels.

We will focus our efforts in gathering evidence, education, and advocacy on the four priority areas of this plan: Groups that are Marginalized and Underserved, Child Passenger Safety, Water Safety, and Safe Sleep.
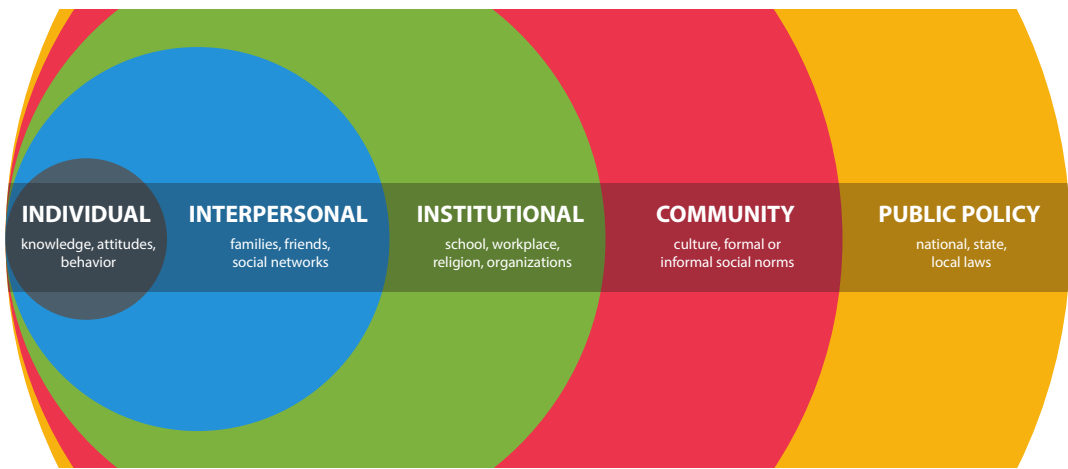
C. Sustain systems change

Reducing unintentional injuries for children does not often involve easy solutions. The great historical progress on this topic over the last 36 years means there are few remaining "quick wins." Catalyzing change, particularly in the hardest-to-reach communities, requires consistent, multi-year efforts to build trust and capacity. We will identify, gather evidence about, and increase the adoption of effective models of injury prevention that are organizationally and financially sustainable, especially in communities that are marginalized and underserved. Over time, this will deepen the quality of our engagement with communities. Rather than exclusively providing short-term education grants, we will help provide localities with expertise and seed funding that will help put them on a path to being self-sustaining and effective at scale for many years. We are asking our generous donors to join us in our shift in priorities so that we can help their contributions have greater, lasting impact.
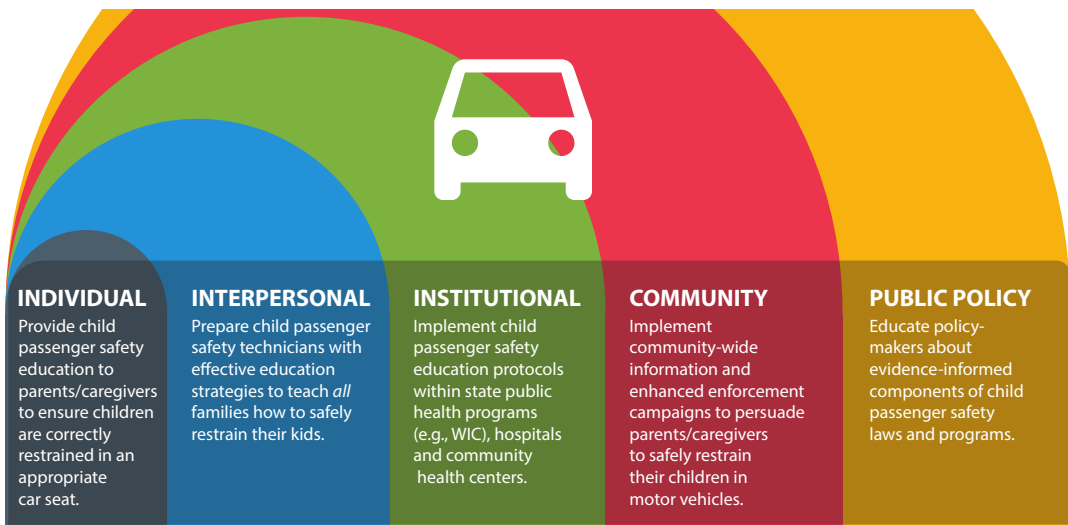
Our view of systems is guided by a social-ecological model,[viii] which considers the complex interplay between individual, relationship, community, and societal factors in producing inequities. In addition to helping to understand the range of factors that put children at risk for, or protect them from, unintentional injury, the overlapping rings in the model also illustrate how factors at one level can influence factors at another level. Creating equitable and sustained systems that support injury prevention for all children will require action across multiple levels of the model at the same time.

Comprehensive Systems Approach: The Example of Child Passenger Safety

INDIVIDUAL	INTERPERSONAL	INSTITUTIONAL	COMMUNITY	PUBLIC POLICY
knowledge, attitudes, behavior	families, friends, social networks	school, workplace, religion, organizations	culture, formal or informal social norms	national, state, local laws

Adapted from McLeroy et al. (1988). An Ecology Perspective on Health Promotion Programs. Education Quarterly; 15(4):351-77.

Child Passenger Safety: Example of the Approach

INDIVIDUAL	INTERPERSONAL	INSTITUTIONAL	COMMUNITY	PUBLIC POLICY
Provide child passenger safety education to parents/caregivers to ensure children are correctly restrained in an appropriate car seat.	Prepare child passenger safety technicians with effective education strategies to teach *all* families how to safely restrain their kids.	Implement child passenger safety education protocols within state public health programs (e.g., WIC), hospitals and community health centers.	Implement community-wide information and enhanced enforcement campaigns to persuade parents/caregivers to safely restrain their children in motor vehicles.	Educate policy-makers about evidence-informed components of child passenger safety laws and programs.

Adapted from Children's Safety Network Child Passenger Safety Change Package

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MEMBERS
The establishment of this group of experts from government agencies, national cross-injury organizations, and partners that focus on equity will be an ongoing process. The group will encourage dialogue and collaboration with the purpose of enhancing the strategic plan's implementation.

Children's National Affiliation

Safe Kids Worldwide is a subsidiary of Children's National Hospital under the supervision of Nathaniel Beers, M.D., M.P.A., F.A.A.P, executive vice president for Community and Population Health.

Endnotes

[i] Adapted from https://www.healthequityandpolicylab.com/underserved-populations-areas-and-facilities

[ii] Adapted from the National Cancer Institute by Dr. Joseph Wright.

[iii] https://www.cdc.gov/healthequity/whatis/index.html

[iv] Adapted from the World Health Organization.

[v] Adapted from https://masspier.americanhealth.jhu.edu/sites/default/files/2022-12/JHU-MassPIER-Toolkit.pdf

[vi] Adapted from https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html

[vii] Source: Child Poverty Report, 2013 (https://consumerfed.org/pdfs/Child-Poverty-Report.pdf)

[viii] Adapted from McLeroy et al. (1988). An Ecology Perspective on Health Promotion Programs. Education Quarterly; 15(4):351-77.

[ix] CDC WISQARS