Considerations for the Inclusion and Prioritization of Protective Factors

As part of its 2018-2022 Statewide Injury and Violence Prevention Plan, the Alaska Statewide Violence and Injury Prevention Partnership (ASVIPP) prioritized the use of a shared risk and protective factor framework for designing and implementing prevention efforts for both intentional and unintentional injuries. The use of a shared risk and protective factor framework is intended to increase the potential for prevention programs to have greater reach across multiple areas of concern and facilitate opportunities to leverage limited resources.[1]

ASVIPP is committed to utilizing the best available evidence to support the development of a shared risk and protective factor approach to injury and violence prevention and ensure the greatest potential for positive outcomes. We understand, however, that what serves as the best available evidence for public health must include a consideration of all types of evidence, not just a hierarchy of methodological rigor. In designing the standards for inclusion of priority protective factors in its work, ASVIPP recognizes the need to take into account the specific social, political, economic and historical contexts of Alaska, as well as the capacity of the public health system, including community-based partners and stakeholders, and the existing research base. Additionally, ASVIPP recognizes the importance of community and Indigenous Knowledge in designing relevant and effective public health interventions. ASVIPP is committed to looking beyond what has historically been measured for solutions.

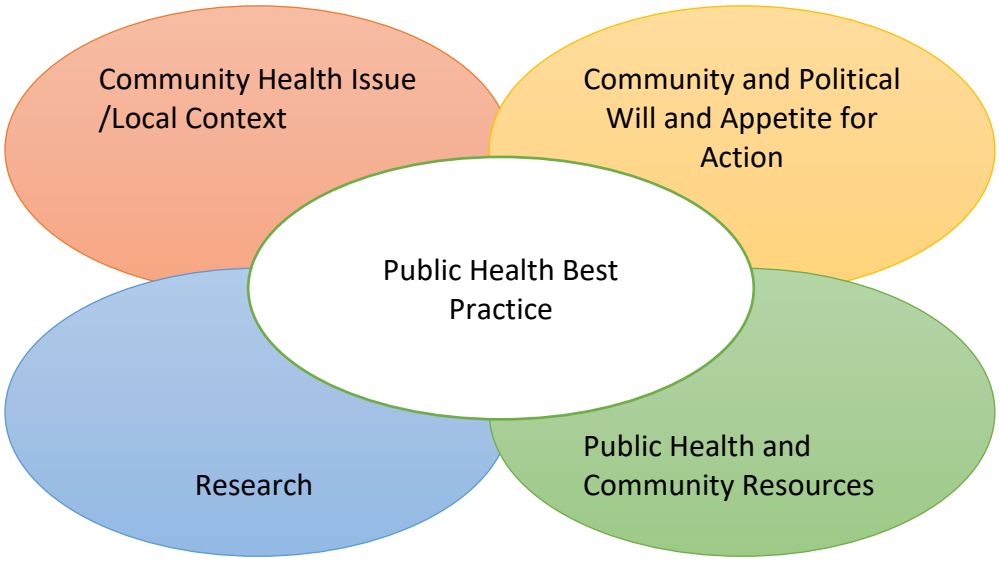

Figure 1: Evidence for Public Health Action adapted from https://www.nccmt.ca/tools/eiph

[1] ASVIPP Plan

Criteria for Inclusion of Priority Protective Factors

1. The factor addresses a health need identified by ASVIPP or a priority/funded local community.
2. The factor demonstrated an influence on two or more unhealthy behaviors or health outcomes.
3. The factor has been cited in two or more peer review studies, reports, or analyses.
4. If the factor does not meet criteria #3, does it reflect a unique culturally relevant approach to prevention work with a community that can incorporate CQI strategies and/or be evaluated for effectiveness?
5. Do the resources exist to implement programming focused on the protective factor?
    a. Funding
    b. Community and political will
    c. Staffing
    d. Knowledge and/or expertise
6. Does data exist to understand the how the associated risk is operating in Alaska and the relationship between the protective factor and risk mitigation? If not, can data be collected?
7. Is data currently being collected that could support program evaluation? If not, can data be collected?