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How older adults would like falls prevention information delivered: Fresh insights from a World Café forum

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ABSTRACT

Translation of falls prevention evidence into practice is problematic. Understanding older adults' views about falls prevention information could enhance delivery of falls prevention resulting in better engagement and uptake of recommended activities. The aim of this study was to examine the views and preferences of community-dwelling older adults about seeking and receiving falls prevention information. A community forum using a modified World Café approach was conducted. Participants discussed five topic areas in small groups, under the guidance of table facilitators. Perspectives were captured on paper. Thematic analysis was

conducted to identify factors that influence participants' engagement and uptake of information. Seventy-three older adults participated in the forum covering wide-ranging preferences around falls prevention information. Personal experience was considered the key influence on an older adult's decision to initiate seeking information. While health professionals were often approached, alternative sources such as public libraries, peer educators and seniors' organisations were also favoured as credible sources of information. Older adults proposed falls prevention information should be delivered with a positive tone, coupled with highly valued qualities of respect, empathy and time to listen to foster motivation to engage in recommended activities. Consumer-focused practical strategies were proposed to potentially improve future design, communication and dissemination of falls prevention information. This improvement could enhance engagement of messages and subsequent uptake of falls prevention recommended strategies.

KEY WORDS **-** accidental falls, consumer health information, community participation, health education, qualitative research.

Introduction

Falls among older adults are a major problem given that they are the leading cause of injury-related death and hospitalisation for adults aged 65 and over (Ballestas *et al.* 2011). Falls can have a substantial negative impact on an older adult as a result of the physical injuries, psychological and social consequences such as developing a fear of falling leading to a loss of self-efficacy and activity avoidance (Arfken *et al.* 1994; Scheffer *et al.* 2008; Tinetti *et al.* 1994). While there is strong evidence that falls prevention interventions such as exercise, and home hazard modification are effective in reducing falls among community dwelling older adults (Gillespie *et al.* 2012), a review of 98 randomised trials found that on average only 50% of participating older adults were likely to adhere to recommended falls prevention interventions after 12 months (Nyman and Victor 2012).

Facilitators and barriers to uptake and adherence to falls prevention strategies amongst older adults are complex (Culos-Reed *et al.* 2000). Biopsychosocial factors at the interpersonal, environmental and individual levels affect adherence (Culos-Reed *et al.* 2000). Interpersonal factors include the individual's social context and communication with their health professional (Culos-Reed *et al.* 2000). Environmental factors influencing adherence include accessibility, transport, costs and convenience (Bunn *et al.* 2008). Studies have suggested that falls prevention messages be delivered positively to facilitate uptake of falls prevention strategies (Dickinson *et al.* 2011a; Haines *et al.* 2014; Yardley *et al*. 2007). Individual factors include older adults finding falls a threat to their autonomy (Dollard *et al.* 2012; Host, Hendriksen and Borup 2011), not finding falls prevention messages personally relevant, having poor levels of falls prevention knowledge (Bunn *et al.* 2008; Haines *et al.* 2014; Hill *et al*. 2011a) and not wanting to engage in offered formats for managing concerns about falls (Dorresteijn *et al.* 2012).

Some researchers have therefore suggested that falls prevention messages be presented positively (such as maintaining autonomy) to facilitate and increase uptake of falls prevention strategies (Dickinson *et al.* 2011a; Haines *et al.* 2014; Yardley *et al.* 2007) and that general practitioners should encourage older adults to engage in falls prevention activities (Host, Hendriksen and Borup 2011; Yardley *et al.* 2006). These studies have asked older people what they think about falls, barriers they see to participating in falls prevention strategies, how likely they are to take up interventions or what type of programme they would participate in to manage their concerns about falls. No published studies have asked older adults when and how they might initially seek out falls information in the first place and their conceptualisation of how falls prevention information should be provided to them.

Given older adults' reluctance to engage in falls prevention activities and their perception that falls prevention is not personally relevant (Haines *et al.* 2014), an understanding of the views and preferences of the community-dwelling older adults in seeking and receiving falls prevention information could improve engagement with falls prevention activities. Older adults have unique insights based on their lived experience, so their involvement should be a prerequisite step to designing such messages. Moreover, social marketing concepts in health indicate that a consumer focus is essential to motivate behaviour change (Egger, Spark and Donovan 2013). A systematic review found that patient resources such as brochures were more relevant and coherent to patients after seeking their views on how such resources should be designed (Nilsen *et al.* 2006).

Therefore, we decided to engage older adults as research partners in a community-based participatory research forum (Wallerstein and Duran 2006). This research model focuses upon the importance of involving consumers and communities in research in meaningful partnerships. The purpose of this study was to examine the views and preferences of community-dwelling older adults about seeking and receiving falls prevention information.

Methods

Design

A community forum was conducted using a modified World Café approach (Jones *et al.* 2013). The World Café approach is an interactive exchange of insights on issues achieved through a 'conversational process' among groups (Fouche and Light 2011). To our knowledge, deriving information from a large group through a structured interactive approach has not been used previously to explore falls prevention with older adults.

Ethics

Ethical approval for the study was obtained from the University's Human Research Ethics Committee. All the participants provided written consent prior to commencement of the forum.

Participants and setting

A convenience sample of people aged 60 and over in Perth, Western Australia (WA), was invited to participate in the Falls Prevention World Café community forum. Advice on recruitment strategies specifically targeting community-dwelling older adults, and the design and conduct of the forum, were obtained from a team of people including an expert consultant on community-based participatory research and a large community organisation that provides falls prevention information throughout WA.

The forum was publicised in various media to reach out to diverse groups of community-dwelling older adults. These media platforms included seniors' radio shows, seniors' group meetings, seniors' newspapers, flyers, and health websites.

Areas of discussion for the community forum

The topic areas for the forum were designed by the research team to stimulate discussion and to explore older adults' needs and concerns about falls prevention information, falls-related knowledge, attitudes, practices and any other determinants that surround information preferences. The initial topic wording and questions were refined in collaboration with the community organisation. Subsequently, two older adult community members were also asked to provide feedback about their understanding of the questions. Five questions based on the topics were then piloted with an older adult walking group and subsequently were finalised after obtaining their feedback.

The five questions and underlying rationale for each question that were used to guide the forum discussion were:

1a. What would trigger you to find falls prevention information? (Factors older adults believe trigger their search for falls prevention information).

1b. Where would you prefer to go to get falls information? (Understanding older adults' personal approaches and sources for seeking falls prevention information).

2. What makes falls prevention information more meaningful to you? (Understanding and addressing older adults' preferences when designing falls prevention communication strategies in future).

3. Who do you prefer to receive falls prevention information from? What qualities would you like the person to have? How would you feel about a trained older person (similar to you) presenting falls information? (Understanding older adults' personal experiences and preferences for who delivers falls prevention information to them).

4. How can people over 60 reduce falls? (Understanding older adults' current perceptions about what strategies can be undertaken to prevent or reduce falls).

5. What stories can you share that helped yourself or a friend to avoid falls? (Understanding older adults' perceptions of the problem of falls and falls prevention in general).

World café community forum procedure

The forum procedure has been described in more detail elsewhere (Bulsara *et al.* in press). The forum was run based on World Café's seven integrated principles (Brown and Isaacs 2005, Fouche and Light 2011). Briefly, these are: (a) set context; (b) create a hospitable space; (c) explore the questions; (d) encourage everyone's contribution; (e) connect diverse perspectives; (f) listen together for patterns; and (g) share collective discoveries. At the preparation stage (prior to the forum), cafe table facilitators were invited for a briefing. These table facilitators were either health care professionals or university academic staff who volunteered to facilitate the small group table conversations at the forum. The table facilitators were provided with information about the World Café's principles and approach, relevant current falls prevention evidence and the outline of the planned community forum by one of the researchers (LK).

The research team's main facilitator (CB), who was experienced in community participatory research, facilitated the forum. Participants were welcomed by volunteers and invited to sit in groups of six to eight people at a table of their choice. The forum lasted three hours, which included time for morning tea. The forum commenced with a welcome address followed by a briefing of the context for discussing falls prevention, and an introduction to the aims of the forum by a member of the research team (A-MH). The main facilitator then explained how the forum would be conducted.

Café table facilitators led the table conversations, with each round of conversation lasting approximately 15 minutes. During each round, the forum participants discussed their

views and committed them to pieces of small paper provided. At the end of each round, these pieces of paper were collated, and the table facilitator moved to the next table of participants. At the final stage of the forum, the forum main facilitator led the table facilitators in summarising key responses for each question, which were then presented to the group on large summary sheets. This was an opportunity for forum participants to provide any further input and feedback and also served as a form of member checking before the forum concluded. Participants were also requested to provide feedback about the forum by completing an evaluation form before they departed the venue.

Data analysis

Following the forum, data in the form of participants' comments on 438 pieces of paper, summary sheets and completed forum evaluation forms, were transcribed and imported into NVivo Version 10 for Windows (QSR International Pty Ltd 2012). Data were thematically analysed (Braun and Clarke 2013) by two research team members who had been present at the forum, with each researcher independently analysing the data. Data were initially coded and key themes following the questions of the forum were assigned. The two research team members then discussed their initial coding and themes in order to reach consensus on themes and hierarchy of coding structure. Emerging key themes were displayed as an explanatory model (Miles, Huberman and Saldana 2014). A third researcher who was at the forum and had falls prevention expertise then reviewed the emerging themes. Any difference of opinion was discussed among the researchers until agreement was reached. Quantitative responses obtained from demographic data and participants' feedback about the forum were imported into SPPS Statistics 22. Descriptive statistics were used to summarise the data.

Findings

Participant characteristics

Seventy-three older adults participated in the community forum, of whom 86% were women. Participants' mean age was 70 years old (range 60 to 87 years), and 58 participants (80%) were fully retired. More than half of participants (65%) had completed a secondary education, a post high school diploma or a vocational certificate. Based on self-reported postal codes, 53 participants (73%) lived in high socio-economic status areas based on the Socio-economic Index of Relative Disadvantage for areas (Australian Bureau of Statistics 2013a; Australian Bureau of Statistics 2013b). Forty-three participants (59%) reported that they had not fallen in the past 12 months, while 30 (41%) reported one or more falls in the past year. Forty-eight (66%) participants had not discussed falls with either their general practitioner or any other health professional. Participants' feedback about the format of the forum has been reported elsewhere (Bulsara *et al.* in press). Participants strongly reported that the forum was an empowering experience and 92% reported that the forum covered issues important to them.

Themes pertaining to factors that trigger a search for falls prevention information

Feedback from many participants highlighted that personal experience strongly influenced their decision to initiate seeking out falls prevention information. As one participant explained 'it doesn't mean anything to me unless it happens'. Primarily, having personally experienced a fall or near miss was reported as the key reason to start looking for information. Other personal factors that influenced participants' decisions to seek falls information included medical conditions that raised their risk of falling, such as 'when my balance was compromised after having chemo' or vertigo.

Triggering factors beyond personal experience included finding out about a friend or relative who had fallen. A forum participant described seeing 'friends fall, breaking hips and

smashing their knees' and another described witnessing the 'distress of a person who has fallen'. A smaller number of participants also reported that they decided to seek out falls prevention information after a media or awareness campaign including advertising, such as seeing a poster or pictures about falls, or reading about personal stories in community or seniors' newspapers.

Themes pertaining to the sources and approaches to find falls prevention information

Participants reported diverse approaches for seeking falls prevention information, although the great majority reported seeking information from health professionals and seniors' organisations. Health professionals, including doctors, allied health professionals and pharmacists were mentioned repeatedly. Other health-focused organisations such as the Injury Control Council of Western Australia (ICCWA), and the Western Australian Government Department of Health were reported.

Alternative sources of information which were seen to be credible sources by participants were seniors' organisations such as Council on the Ageing (COTA), retirees groups and local seniors' centres. Senior-specific interest groups such as seniors' exercise groups, bingo, or seniors' social gatherings, where there were opportunities to discuss health related topics with peers, were frequently reported as important settings for seeking falls prevention information.

Broad groups that deliver services for the whole community were another source favoured by participants for seeking and receiving falls prevention information. One participant stated 'libraries are a good and often-used resource', a sentiment reiterated by many other participants. They suggested that libraries could display posters with pictures and large print to attract attention or provide information through workshops or by disseminating

falls prevention leaflets. Local councils, shopping centres, sporting venues and public transport hubs such as bus or train stations were also reported to be places where reliable information could be sought. Media such as health websites and radio stations that focused on older adult audiences were suggested as sources of information, as were community seniors' newspapers.

Themes pertaining to factors that make falls prevention information more meaningful

Participants indicated they would prefer falls prevention initiatives that included information and practical strategies about how to manage their risk of falls. They also reported wanting to receive up-to-date information regarding other areas, such as knowledge about statistics related to falls (for example, how common falls were), and information about the consequences of falls. In particular, they sought falls prevention strategies that were practical, convenient and inexpensive. For example, a local public community centre exercise class was suggested as being more economical and accessible compared to paying for a membership at a private gym.

Participants wanted information that was simple and easy to read, and suggested that resources that were provided focus on visual illustrations and pictures rather than just words. Participants preferred receiving information that focused on positive 'prevention is better than a cure' recommendations and did not use the negative element of fear to encourage seeking information. They described their preference for positive images by stating that information should include 'pictures that help build confidence' as well as depicting an element of 'fun and a cheerful presence' rather than images which were associated with limiting physical capacity. One participant highlighted this by stating that messages should 'cultivate a drive and motivation to do it [prevent falls]'.

Themes pertaining to the preference for receiving falls prevention information from trustworthy sources

Forum participants reported that they would be receptive to receiving falls prevention information from either health professionals or trained non-professionals. They also favoured information being given by a peer as long as the person was 'properly trained'. Peers were seen as people who could engender emotional connections by sharing personal stories about their experience, and this approach was strongly favoured. In the words of a participant, a peer was 'someone like us…same age as self, circumstances that you can relate to, similar cultural background'. Other participants described the nature of peer relationships. It was suggested that a peer was someone who 'can talk from life experience as seniors have difficulty accepting information from someone who is young' and another commented because 'they [younger people] don't know what it is to fall'.

Regardless of who the person delivering the information might be, participants believed that they should be trained and be competent. Competency was described by the participants as 'the need to understand the audience; what do they need? What do they want?' Further to this, they reported that it was important that delivery was culturally appropriate and that the person should be accustomed to working with older adults. Participants also suggested other important attributes: that the person should be patient, be a good listener and possess credibility regarding falls prevention.

Themes pertaining to interpersonal communication

While qualifications, training and competency were perceived as important attributes, participants emphasised that the quality of the interpersonal communication between the educator and the older adult was crucial. Specifically, participants noted that it was important

that the person be 'someone who is understanding and can communicate clearly'. They also desired the person to have the skill and ability to deliver messages confidently while being approachable. A forum participant elaborated that their doctor 'talks to me like a real human being, draws pictures for me and is accessible. He tells me I can call him anytime. He is friendly, empathetic and patient'. Many participants highlighted that it was important that the educator communicate with 'respect and empathy, and have time to listen,' when delivering falls prevention information, for example:

> Caring, trust and respect before [the] message can be received. Respect is how you listen and have the time to listen.
>
> Have empathy; try to understand where that person is in their current position…with the horrible realisation that your body can no longer be relied upon.

Highlighting the importance of respect in communication approaches, a participant stated that 'respect has gone out the window'. Some participants expressed that young people lacked respect for (and knowledge of) older adults and their preferences.

Themes pertaining to positive evidence-based perceptions and strategies to reduce risk of falling

Findings from the forum indicated participants' attitudes towards preventing falls differed and they also reported engaging in a diverse range of falls prevention strategies. A group of participants in the forum expressed the view that they were proactive and receptive to health information, and felt they were committed to addressing the problem of falls. For example, one participant stated his/her reflection that 'after a fall I analysed it, why did it happen? What could I do to change it? how can I avoid it happening again?'

Falls prevention practices described by participants could be broadly subdivided into positive/evidence-based strategies and non-evidence-based strategies. Evidence-based

strategies that were identified reflected a focus on healthy ageing and included strategies that were related to vision, podiatry/footwear, home hazards, exercise, medication and appropriate use of aids. Examples of these practical strategies for preventing falls included wearing shoes with a good sole grip; having one's eyesight tested; taking care when wearing bi-focal glasses; getting a review of medication that may affect their balance; and exercising regularly in order to strengthen muscles and maintain good balance.

Themes pertaining to non-evidence-based perceptions and strategies to reduce risk of falling

A large number of forum participants reported practicing a range of non-evidence-based strategies they considered may reduce their risk of falling. These practices could be grouped under three related domains, which were broadly defined as accepting the limitations of the ageing process, undertaking avoidance strategies primarily based on fear of falling, and finally, avoiding activities that were perceived as requiring the older person to take risks. Participants who suggested that it was important to accept the limitations of the ageing process suggested that this approach to falls prevention was realistic and recognised that the body becomes less robust as one gets older. One participant commented that one should be realistic about one's age and to ask for help when it is needed. Another participant described 'feeling old and frail'. Another participant described this as having an 'awareness of reduced agility' while another stated that you needed to 'slow down, accept changes in body'.

Some participants were practising strategies that were based on their fear of falling. These participants expressed heightened anxiety and stated that they planned their activities with high levels of caution and restricted their activity. One participant stated she was 'so anxious about falling [that I] restrict behaviour too much'. Comments included 'take it easy don't rush' and 'stay vigilant'. Avoidance of activities that were assessed by the older person as being risky was also reported as a falls prevention strategy, with some participants

intentionally limiting certain activities to accommodate their perceived increased falls risk. Comments included 'know your capabilities' and 'do not go somewhere perceived dangerous [*sic*]'. In particular, one participant suggested 'don't walk on your own if you are fragile'.

Themes pertaining to community awareness and an understanding about falls and falls prevention

The forum participants suggested repeatedly that falls prevention 'should target the wider population' and desired that education programmes should 'target all people – not just seniors – should be owned by all'. They perceived that falls were 'everybody's responsibility'. Consequently, a number of participants suggested that raising broad community awareness and targeting all ages to work together to prevent falls among older adults was important. This seemed to apply in particular to environmental considerations, with many participants suggesting that local governments, transport, trades, town planners and architects of buildings and public venues should be informed about falls prevention for older adults and adopt falls prevention recommendations in their practices. Other suggestions related to this theme were that personal equipment such as walking sticks should be 'more trendy and decorated' and that older people needed to be portrayed in the media as 'active healthy people'.

Themes summarised in an exploratory model

The key themes identified through this World Café approach as likely to influence engagement and uptake of falls prevention information run across all domains at an individual, group or societal level. These themes are reflected in a summary explanatory model, as shown in Figure 1.

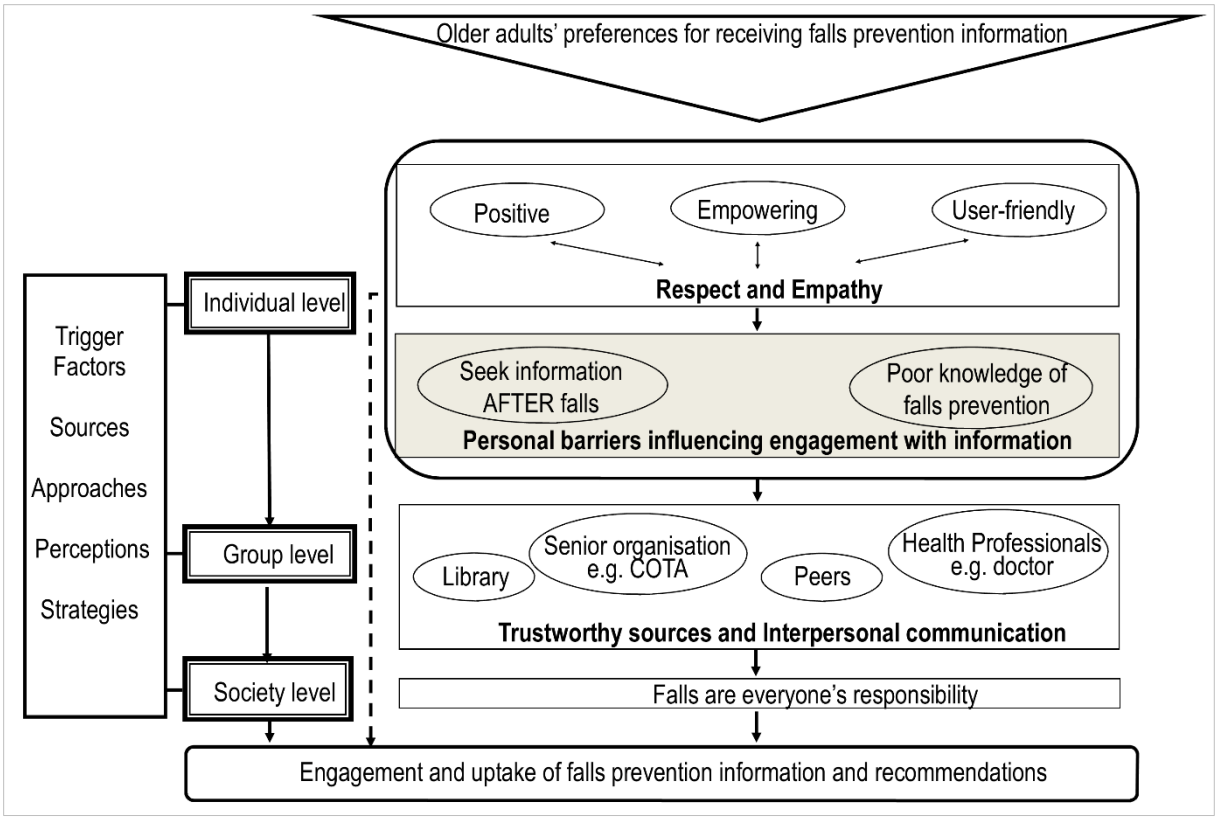

Figure 1. Explanatory model of older adults' preferred factors influencing engagement and uptake of falls prevention information and recommendations based on the World Café forum data.

Note: COTA: Council on the Ageing Australia.

Discussion

A community-based participatory research forum took a consumer-focused approach to seek older adults' views regarding falls prevention information (Egger, Spark and Donovan 2013). The forum identified older adults' preferences for seeking and receiving information about falls prevention at an individual, group and societal level. Participants commonly reported that they sought information about falls after a triggering event such as having a fall or nearly falling (individual level). This finding assists to explain why previous studies report that some older adults do not see falls prevention activities as personally relevant (Bunn *et al.* 2008; Haines *et al.* 2014). One large randomised trial reported that when researchers invited over 40,000 older women to have their balance screened, only 11% agreed to participate (El-Khoury *et al.* 2015; Lamb and Lamb 2015). Our results suggest that information about

preventing falls and invitations to engage in falls prevention activities may be screened out by older adults as not personally relevant if they have not had a personal experience of falling. Other research has also shown that many older adults do not think that they are at risk of falls, and do not consider that they would benefit from engaging in falls prevention strategies (Haines *et al.* 2014). Hence, information may need to be provided in two distinct formats: preventive information for older people who have not fallen, and comprehensive tailored information for those who have fallen. For the first group, it is necessary to raise awareness about falls as a relevant topic for all older adults, through highlighting such issues as the frequency and impact of falls and falls injuries, and that some falls and serious injuries such as hip fractures can occur in generally well older adults as well as frailer older adults. This may assist in alerting and providing a rationale for older adults to identify with, and subsequently view the information provided. It has also been reported that perceiving that falls could result in injury was a predictive factor in whether older people engaged in exercise to reduce falls risk after hospital discharge (Hill *et al.* 2011b).

Moreover, since older adults who have not fallen may not seek information from health professionals, using diverse and credible community-based sources or public agencies (group level) may be a feasible means of reaching this sub group of older adults prior to them falling. These older adults could be provided with health promotion-focussed falls prevention information through public libraries (which were described as a preferred source) and seniors' organisations, with the aim to raise their awareness about falls and about the health benefits of engaging in falls prevention strategies such as exercise. These alternative avenues of information dissemination are important, as many forum participants saw no reason to seek information about falls from a health professional if they had not experienced a personal triggering event. Low levels of knowledge about falls prevention may have contributed to this. A substantial number of participants reported practising non-evidence-based strategies to

prevent falls, such as slowing down, a finding supported by others (Haines *et al.* 2014; Hill *et al*.; 2011a). This is a problem for reducing falls at a preventive level among the older population because increasing knowledge and capability are viewed as fundamental to health behaviour change (Michie *et al.* 2005). In particular, increasing older adults' knowledge about falls and falls prevention has been reported to be an effective means of raising motivation and confidence to engage in falls prevention strategies (Haines *et al.* 2011, Hill *et al.* 2011b).

Health professionals and doctors have the potential to be effective facilitators in prevention and management of falls in the community or in hospitals or at discharge for those older people who have already fallen, but other studies have found that information provided is rarely evidenced based or presented in an easy to understand format (Dickinson *et al.* 2011b; Lee *et al.* 2013; Tzeng and Yin 2014). The findings at the forum indicate that it is important that healthcare providers recognise that older adults might be receptive to seek and receive falls prevention information around the time of a fall, but that it is crucial that the information is shared in a respectful and empathetic manner. This is consistent with treating older adults as empowered decision-makers and could improve likely engagement and uptake of falls prevention messages (Nyman *et al.* 2011). Positive rather than negative messages about falls prevention appealed to participants, a finding which is supported by other studies in this area (Bunn *et al.* 2008; Yardley *et al.* 2007).

Respect, positiveness and connectedness are consistent with motivational strategies (Wlodkowski 2008) which aim to enhance engagement with information provided. It has been proposed that using trained peers to deliver falls prevention information could be an effective means of raising older peoples' engagement in falls prevention strategies, with benefits seen to derive from the peer-to-peer connection (Khong *et al.* 2015; Peel and Warburton 2009). This may be an avenue where older adults as peers could frame falls prevention messages using personal insights, stories and terms familiar to their peers, an approach which was

favoured by forum participants. This can be a powerful strategy to deliver real messages that resonate in a way that creates an emotional connection with the peer audience. Peer-led education programmes using peer educators for people with chronic disease including arthritis have been shown to be effective in facilitating participants' self-efficacy and self-management of their symptoms (Lorig, Ritter and Gonzalez 2003, Swerissen *et al.* 2006). However, there is a need for quality studies to evaluate the effectiveness of the peer education approach in falls prevention.

A strong finding from our forum was the participants' assertion that all people should be aware about falls, as 'falls are everyone's responsibility'. Falls prevention messages should be disseminated to the broader community (society level) to raise awareness and knowledge about the benefit of older adults undertaking falls prevention strategies such as exercise. Broader community awareness may assist in providing older adults with community and social support to more readily engage in falls prevention strategies.

This study has several limitations that may reduce the generalisability of study findings. Older adults who attended the forum were from a generally higher socioeconomic background and most of them were women. Additionally, although the location of the venue was considered central, participants were required to travel either by car or public transport. Hence these participants may be more motivated and proactive to provide their thoughts about and gain information regarding falls prevention and be a more mobile group of those older adults living in the community. Nonetheless, 41% of the World Café sample had fallen in the past 12 months, which is reflective of a community-dwelling older adult population.

Conclusion

The World Café forum generated fresh insights and practical consumer-focused strategies about when older adults seek falls prevention information, what they value and how they perceive that information should be provided. Service providers and health professionals should be aware that older adults are most likely to seek information after a personal experience of a fall. Therefore, a trained and competent health professional should be available to deliver comprehensive and tailored education about falls prevention when an older person seeks information following a fall. However, health professionals should also recognise the preferences of older adults by sharing this information with respect, empathy and time to listen. Falls prevention information that focuses on raising awareness about falls and knowledge about the benefits of participating in falls prevention activities should be also presented to older adults who have not fallen through a wide range of credible community sources, in particular libraries or involve peer educators, rather than being provided only in a medical or quasi-medical type setting. Finally, the older adults at the forum felt that falls are everybody's responsibility, and future design of falls prevention programmes should seek to raise awareness among the broad community population about the risk of falling and available strategies regarding falls prevention.

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Conflict of interest

The authors declare that they have no conflict of interest.

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