Recommendations for the Development of an Advocacy Campaign for Public Act 653’06-Michigan’s Health Disparity Law

By

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Abstract

In the history of the United States, the general health outcomes of minority populations have *never* equaled the health status of Caucasians. The nation’s general life expectancies and the overall health status have improved dramatically for all Americans in the last six decades. However, excess morbidity and the decreased life expectancy in the general health of minority populations have proved to be stubbornly resistant to improvement. Minority populations in Michigan are needlessly suffering and dying prematurely due to social inequities that manifest themselves as disparate health outcomes.

The Michigan legislature passed Public Act 653’06 - the Health Disparities Research and Education Act in 2007 to address this deplorable situation. The law was passed, however, without the appropriate funding, infrastructure, and possibly intent to address the health disparity issue.

This paper calls for the creation of a public health advocacy campaign to inform the general public about health disparities, impact public opinion, and ultimately gain the attention of the legislature who can make implementation of Public Act 653’06 a reality.
Recommendations for the Development of an Advocacy Campaign
for Public Act 653’06-Michigan’s Health Disparity Law-

On January 8, 2007, Governor Jennifer Granholm signed Public Act 653’06-The Health Disparities Research and Education Act (PA 653) into law. This statute was designed to address the increased rates of morbidity and mortality observable in minority populations (State of Michigan, 2007). The Michigan Department of Community Health (MDCH) identified these observable differences in incidence, prevalence, mortality, burden of disease, and other adverse health conditions as “health disparities” and deemed them to be investigated with the intent to eradicate them (Michigan Department of Community Health, 2007). MDCH assigned the Health Disparity Reduction and Minority Health Section (HDRMHS) as the coordinating body within state government with spearheading the effort to eliminate health disparities and implement PA 653 (ASTHO State Health Agency Survey, 2007). Unfortunately, PA 653 was passed void of the financial appropriations necessary to adequately fund the health disparity issues for which the law was designed to address. Consequently, the law has lacked financial support by the legislature and is still not properly implemented.

Health disparities in Michigan’s minority populations are evident from the cradle to the grave. The infant mortality for African American and Latino babies is respectively 3 and 2.5 times that of Caucasian babies (Michigan Department of Community Health, 2007). African American male life expectancy in 2005 was approximately equal to the life expectancy of Caucasian males in 1950 (Michigan Department of Community Health, 2007). Additionally, the following selected statistics highlight some of the disparate health outcomes experienced by people of color in the State of Michigan and point out the urgency of the issue.
- Diabetes prevalence is 18% for Arab Americans, 15% for Native Americans, 12% for African Americans, 8.8% for Latino Americans and 6.8% for Caucasians (Michigan Public Health Institute, 2008).

- Almost 50% of the Arab Americans/Chaldean population reported being told that they had high cholesterol compared to rate for Caucasians, (Michigan Department of Community Health, 2009a), and

- In general, American Indian/Alaska Native adults are 60% more likely to have a stroke than their White adult counterparts (Michigan Department of Community Health, 2009b).

The prevailing issue is that individuals in Michigan’s minority populations are needlessly suffering and dying prematurely due to social inequities that manifest themselves as disparate health outcomes. Legislators passed PA 653 in 2007, as a remedy to address and ultimately alleviate health disparities. Unfortunately, two and one half years after passage, HDRMHS still lacks the funding, infrastructure, and possibly even the intent to successfully implement PA 653.

Public health advocacy is often referred to as the structure or process that is used to overcome obstacles to public health goals (Chapman & Lupton, 1994). It has proved to be important in educating the public, changing public opinion, and influencing policy-makers (American Public Health Association, 2009).

This master’s thesis is designed to make recommendations for a public health advocacy campaign designed to influence and persuade Michigan’s policy makers on the merits for full implementation of PA653. It will entail a review of the literature on minority health in Michigan, public health advocacy, media advocacy, grass roots leadership, and community based participatory research, and the economic impact of health disparities on the State of
Michigan. This paper will address two of Public Health’s Core Competencies for providing essential public health services to the public. It will represent a set of skills, knowledge, and attitudes necessary for the profession. These competencies are not embedded in a specific public health discipline, but transcend specific components of the field to be pertinent across all disciplines (Council of Linkages. 2001). The recommendations made in the development of the public health advocacy plan will incorporate the following essential services from the Public Health Core Competencies:

- Number 3-Informing, educating, and empowering people about health issues, and
- Number 6-Enforcing laws and regulations that protect health and ensure safety (Council of Linkages, 2001).

Methods

The intent of the literature review was to discover how to launch a successful public advocacy campaign for full implementation of PA 653. The literature review consisted of surveying sources that examined general advocacy and public health advocacy methods that might prove successful in this effort. In order to understand the topic, “advocacy” and historical references related to “public health advocacy” were researched. This led to the discovery of the 1986 Ottawa Charter for Health Promotion, a seminal reference in the support of public health advocacy. These documents along with other historical references led to the examination of the various components of a successful public health advocacy campaign.

The very nature of advocacy rests on the belief that a situation exists that needs to be amended. This requires a segment of the population influencing and ultimately persuading policy makers to change or enact decisions that the advocates support. Policy makers generally gauge public opinion and make decisions according to the mood and sentiment of their
constituents on those particular topics. Occasionally, a policy maker will take a stand on a topic and attempt to change public opinion from their position of power. However, most often, they are trying to fulfill the wishes of their constituents. This brought about the examination of “public opinion” as a key term.

Policy makers gauge public opinion from the correspondences they receive and the writings or popular slant of the topic in media. They routinely engage their staffs in accessing public opinion from media resources. This realization lead to the investigation of the key words, “media advocacy”, “print advocacy”, “media campaigns”, and “changing public opinion.” By examining these words, it led to the importance of leadership and “grass roots advocacy” as key terms in examining the changing of public opinion.

Advocates are usually members of the general public who have a passion to change the condition surrounding a topic. If they can generate enough synergy around the topic, policy makers will often join the movement and make the necessary changes the public is demanding. This “bottom up” approach requires the empowerment of ordinary citizens and communities. Consequently the key words, “empowerment”, “community organizing” and “grass roots leadership” became topics of interest.

The myriad of literature surrounding these terms required the development of a system for selection of resources. All of the key words were surveyed first from a historical frame of reference in order to get the original intent of the topic. Peer reviewed journals, websites, and literature from key organizations that have vested heavily in developing these topic areas were reviewed. Recent publications that investigated these topics were also reviewed for a more current analysis of these keywords. The reviewed sources were used to develop the literature
review on launching an effective public health advocacy campaign for effective implementation of PA 653.

Literature Review

The State of Minority Health

Multiple statistics from the MDCH continue to point to the disparate inequities that exist for minority populations (Michigan Department of Community Health, 2007). In some instances, the difference in disease rates is increasing in the face of the Department’s effort to stem the tidal wave of disparities. The HDRMH, MDCH’s coordinating body to address health disparities, in November, 2006 revised their Strategic Framework to address this imploding situation (Michigan Department of Community Health, 2006). Their function is to:

- Vision Priority A-Improve the health of Michigan citizens and promote safe and supportive environments in every Michigan community,
- Vision Priority B-Collaborate internally and externally with partners who have shared public health priorities,
- Vision Priority C-Design, coordinate and integrate data systems to provide more robust state and local public health data to better serve the public,
- Vision Priority D-Assure the existence of a strong and effective state and public health workforce, and
- Vision Priority E-Develop effective communication, marketing, and branding capability to help policy-makers, funders and the public value the importance of the state and local public health system.

The creation and implementation of the strategic framework for the reduction of racial and ethnic health disparity is subsumed under Vision Priority A.
Public Act 653’06 (PA 653), which took effect on January 9, 2007 mandated the MDCH to address the racial and ethnic disparities facing Michigan’s minority populations by:

1. Developing and implementing an effective statewide strategic plan that establishes minority health policy,
2. Establishing a permanent infrastructure that addresses health disparities and allows for the collaboration with minority coalition,
3. Promoting public and professional education that includes implementation of culturally and linguistically appropriate disease prevention programs,
4. Providing resources for minority programs, development of evidence-based and educational treatment programs and resource materials,
5. Promoting minority recruitment in the healthcare and social service professions, and
6. Mandating the establishment of an evaluation plan and an accountability criteria that would assist in the measurement of these objectives (State of Michigan, 2007),

Both the Strategic Framework and PA653 charge the HDRMH with the reduction of health disparities as their major responsibility. However, the law was passed without the financial appropriations necessary to enable the HDRMH Section to adequately fulfill their responsibility.

Michigan identifies individuals whose heritage can be defined as 1.) African-American, 2.) Hispanic or Latino, 3.) American Indian, 4.) Asian or Pacific Islander and 5.) Arab or Chaldean as representing minority populations (Michigan Department of Community Health, 2007). The federal Office of Minority Health (OMH) recommends a systems approach to guide and organize the planning, implementation, and evaluation of efforts aimed at improving
racial/ethnic minority health—and reducing and, ultimately, eliminating racial/ethnic health disparities (Office of Minority Health, 2009). OMH also recommends any plan should be strategically directed and broadly applied across all efforts conducted for the purpose of improving minority health and reducing health disparities. Michigan has two such plans—the HDRMHS Strategic Framework and PA 653. Unfortunately, having a conceptual framework and a health disparity law on paper without the proper resources is just that—words written down on paper.

In 2007, the HDRMHS had a total budget of $1,480,000. This equals approximately $.70 for each of the two million minority citizens in Michigan (Michigan Department of Community Health, 2007). The Section does not have a line item in Michigan’s general budget. Sixty-one percent of their funding is tied to the Healthy Michigan Fund (HMF) the State’s discretionary funding stream (Michigan Department of Community Health, 2007; ASTHO State Heath Agency Survey, 2007). This unreliable source of income, which funds most of Michigan’s health prevention programs, is often on the political chopping block during Michigan’s budgetary woes (Michigan League for Human Services, 2009).

The HMF, plays a significant role in addressing Michigan’s health disparities. It is the funding source for most of the state’s health prevention and disparity reduction programs. In fiscal 2009, it was cut 13% (Michigan League for Human Services, 2009). In May, 2009, Governor Granholm issued an Executive Order which led to the total elimination of many programs that target minority communities (Michigan League for Human Services, 2009). Given the economic downturn of Michigan’s economy in recent years, this discretionary funding source is under dire attack of being used to fill the financial hole in Michigan’s general budget.
In 2009, the Joint Center for Political and Economic Studies released a study finding that racial inequalities cost the US Health System over $50 billion a year in the four year period of 2002-2006. LaVeist, Gaskin and Richard (2009) conducted an econometric analysis estimating the direct, indirect, and excess medical costs associated with inequities. These authors point to control of this excess cost as a possible way to fund health disparities research and possibly finance health care reform. The US Census Bureau (2009) estimates Michigan’s population at 3% of the total US population. Therefore a rough 3% calculation of the $50 billion dollars loss to inequities is $1.5 billion. This is slightly more than the 2007 budget for the HDRMHS.

The general public often views health disparities as an issue that only impacts minority communities. However, the economic reality of health disparities is one that impacts the entire society. The 2009 fiscal year marks the 9th consecutive year where Michigan’s revenues did not adequately fund the state’s programs (Michigan League for Human Services, 2009). In an effort to cut costs and balance the budget, Michigan has stopped funding many preventative programs that impact the health outcomes for minority residents. Admittedly, state legislators are going to have to make difficult decisions concerning the funding of state programs. Although, cuts to disparity programs will save money in the short run, this tactic is very shortsighted and will cost the loss of life and more money in the long run (Michigan League for Human Services, 2009).

Public Health Advocacy

Public health advocacy language.

The language of public health advocacy must be established in the framework of a clear and concise statement. The message should be one that is easily understood and communicates the requisite action that the public legislative body or decision maker needs to act upon (American Public Health Association Media Advocacy Manual, 2009). The context of the work
resides on the foundation and principles of social justice (Wallack, 1994; Dorfman, Wallack & Woodruff, 2005). Social justice mandates and balances the overall good or benefit of society in conjunction with that of the individual. Although social justice acknowledges the right of the individual, this theory believes that the benefit to society or the overall public good should be valued over individualism (Chapman, 2001). Some of the basic principles supported by the paradigm are shared responsibility, strong obligation for the collective good, and the infusion of the government into a multiple of situations for the public good. It is these values that public health advocates craft into their messages of hope and change.

The language of public health advocacy, although informational, is not value neutral. The very nature of the process causes one to choose a side of an issue to support (Chapman, 2001). The largest barrier to achieving social justice is the competing ethic of market justice which is deeply entrenched in American culture and society (Dorfman, Wallack & Woodruff, 2005). Market justice permeates public health and supports the “John Wayne” persona of rugged individualism. Most of our health education messages are proliferated with edicts of what individuals can do to improve their own health. Inadequate consideration is given to the social determinants of health in which individual decisions are made (Wallack, 1994). Proponents of the market theory believe that demand and supply will transform the markets into the goods and services desired and needed by the public (Dorfman, Wallack & Woodruff, 2005). The basic tenets of the opposing principles of market justice and social justice are highlighted in Table 1 (Dorfman, Wallack & Woodruff).
Public health advocates operate in the tension created by these two paradigms. In the US, most of this tension is the result of the oppositional and well funded corporate forces who adhere to market justice principles and public health advocates who value the construct of social justice (Dorfman, Wallack & Woodruff, 2005). These strong oppositional forces are closely tied to corporate structures that benefit from the capitalized market system. Advocates, however, are geared towards addressing the broader social determinates of health that ultimately influence policy makers’ knowledge, skills, and ultimate decisions. Chapman and Lupton (1994) admonish advocates not to view these activities as random occurrences, but as part of a well orchestrated and constantly evolving system of change. For these activities and choices determine the environment in which public health advocates operate.

Public health advocates find themselves in the midst of a struggle between proponents and opponents of a particular policy. Therefore in order to successfully advocate for change, one must change the perception of the public toward the newly posited position. This requires tremendous energy, innovation, and often downright “moxie” as advocates, who often are faced with limited resources as they strive to make a difference in the public health environment.

Development of a strategic plan.

<table>
<thead>
<tr>
<th>Market Justice</th>
<th>Social Justice</th>
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<td>Self-determination and self-discipline</td>
<td>Shared responsibility</td>
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<tr>
<td>Rugged individualism and self-interest</td>
<td>Interconnection and cooperation</td>
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<tr>
<td>Benefits based solely on personal effort</td>
<td>Basic benefits should be assured</td>
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<td>Limited obligation to collective good</td>
<td>Strong obligation to the collective good</td>
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<td>Limited government intervention</td>
<td>Government involvement is necessary</td>
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<td>Voluntary and moral nature of behavior</td>
<td>Community well-being supercedes</td>
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<td>individual well-being</td>
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SOURCE: Adapted from Beauchamp (1976).
Advocates in public health exist because of their desire to change the prevailing situation into one they view as an improvement for the betterment of the society. Strategic analysis explores three central concepts; identification of the problem, identification of the solution, and who is the targeted population for change (Gomm, Lincoln, Pikora, & Giles-Corti, 2006). When advocates attempt to change public policy, they are usually met with strong and usually well-funded opposition from government, interest groups, established organizations, or sometimes even the general public who hold a differing viewpoint. Therefore, the development of the strategic plan is most important for advancing the public health agenda.

Framing the message.

Freeman, Chapman, and Storey (2007) attest framing as a core skill of advocacy. Dorfman, Wallack and Woodruff (2005) present a three stages advocacy model of Framing Public Health Advocacy. The authors attribute the framing of public health messages as one of the most important aspect of the advocacy initiative. The advocacy campaign begins with the clear statement and understanding of the message being communicated and the requisite action that the public, legislative body, or decision maker needs to take (American Public Health Association, 2009). Several researchers have posited that it is important to define the end of the campaign, from the beginning. This is the true starting point of the initiative (Simon & Lupton, 1994; Dorfman et al., 2005). This targeted approach is necessary to avoid becoming mired in activities which do not advance the initiative. If one does not have a clear and concise understanding of the desired end, it can prolong the process.

Step two of this framing model advises advocates to decide the strategies they will use to achieve their goal. Although some view advocacy as an anything goes process, Chapman and Lupton (1994) constrain advocates that the ends do not justify the means. This step requires a
careful examination of the resources available to both the advocates and their opposition. Once the strengths and weaknesses of the advocates and the opposition are thoroughly investigated, one can develop strategies for the initiative.

Step three involves the actual framing of the public health advocacy message. Framing has been described as, “the labels the mind uses to find out what it know” (Dorfman et al., 2005). It assists in identifying the stereotypes, prejudices, knowledge, and labels the mind used to sort the vast amounts of information processed. A frame establishes the pattern of reasoning and the conceptual structure for understanding the world. It ultimately influences the processing of information and the resultant decision making process (Gillian, 2003). Frames are so powerful that one can generally conceptualize the context of an idea with just a few words (Dorfman et al., 2005). Once the framing of the public advocacy campaign is established, that actual language used to craft the frame is developed.

Dorfman, et al. (2005) have demonstrated that the public’s ability to support an idea relates to their ability to identify with the issue. When ideas are expressed in overarching values, such as fairness, equity, or responsibility, the public has a better chance of identifying with the concept being promoted. Messages replete with excessive details tend to muddle the intent of the public health advocacy campaign.

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**Models of Public Health Advocacy**

**Public health primer model.**

Chapman (2004) developed a public health primer to assist in the development of a strategic plan. His model consists of the following ten questions advocates should ask as they craft the advocacy campaign:

1. What are your objections to the public health issue and why is it advantageous for it to change?
2. Is it possible to develop a position where everyone is respected and “wins” in the end?
3. How can the individuals/groups/or funders important to the decision maker be influenced on this topic?
4. What are the identified strengths and weaknesses of the advocacy and the oppositional viewpoint?
5. What are the clear media advocacy objectives that will be used to influence public opinion?
6. What language and concept will advocates use to frame the issue?
7. What images can be readily identified and connected to the public health media campaign?
8. What sound bites can be used to convey the issue?
9. How can this issue be personalized so the general public will identify with the issue?

10. How can a large number of individuals be organized for support of this issue?

The Public Advocacy Primer Model was designed to assist in the formation of an effective campaign.

**Advocacy coalition framework.**

Sabatier and Jenkins-Smith developed the Advocacy Coalition Framework Model (ACF) in the 1980s in response to limitations observed in policy processing literature (Weible, Sabatier, & McQueen, 2009). This model has been extensively used to develop strategic plans since its inception. ACF was developed to enhance the communication between scholars and practitioners in an effort to develop effective decision making strategies. It creates a system based model that:

1. Integrates most of the stages of the policy cycle,
2. Incorporates aspects of the top-down and bottom-up implementation approaches, and
3. Makes scientific and technical information central to the hypothesis being considered.

The ACF uses causal logic and the resultant hypotheses to build from a set of assumptions. It identifies a three tiered belief system that assists actors in the decision making process. The top tier of the belief system includes core structures that are rooted as normalcy for the individual. This includes identifiers such as liberal, conservative, and other broad labels that define the thought process and general approaches to viewing policy issues. The middle level of the belief model includes applicable subsystems which are moderate in scope and span the policy
environment. These beliefs, although normally resistant to change, can be adapted to differing philosophies when accompanied with proper documentation and refutation to the existing policy thought process. The bottom tier of the belief system is comprised of secondary beliefs. These are more narrow in scope, empirically based, and are more likely to change over time.

Weible, et al. (2009) conducted a critical review of over 80 applications of the ACF model revealed several strengths and weaknesses. The ACF seems to be most applicable to uses involving policy change, learning, and coalition stability. Questions still remain as to the appropriateness of the model to explain coalition stability, external factors impacting policy change and cross-coalition learning. The authors suggest using ACF in conjunction with other policy models for conclusive results.

**Media advocacy model.**

The Encyclopedia of Public Health has a simplistic model that poses several questions that need to be answered in the development of an advocacy campaign. These questions at fundamental as advocates seek change public opinion. The simplicity of the questions does not negate having to think deeply about the answers. It questions assist in focusing ones thinking to the end result or the desired action advocates are trying to promote. These questions when combined with aspects of the other advocacy models allow one to approach the campaign in a manner that will be well understood by everyone involved. Naturally, the first rule is to have a clear, concise statement with the desired end in mind. Although the questions are short and right to the point, the thought and the answers the stem from these questions are thought provoking. The questions are:

1. What is the problem being highlighting?
2. Is there a solution to it? If so, what is it?
3. Whose support do you need to gain in order to make the solution happen?
4. What needs to be done do or said to get the attention of those who can make the solution happen? (Encyclopedia of Public Health)

Leadership and Advocacy

A public health advocacy campaign is one in which the individual or organizations are working to change the status quo concerning a situation. Although one may have a group of individuals that support a particular cause or belief that an issue should be handled differently, without leadership one just has an informed gathering. Kent (2001) defined the purpose of leadership as creating direction and the unified will to pursue it through the development of individuals’ thinking and valuing. Leaders play a major role in orchestrating the need for change in their followers. The attributes of leaders are based on the type of actions they cultivate from others and the impact they have (Kuhnert & Lewis, 1987). They often perceive future change and align themselves to benefit from the environment (Conger & Kanungo, 1987). It is with the addition of credible leadership that this gathering of individuals can amass strength and turn this directed energy into action for change. Although, there are multiple leadership styles, charismatic and transformational leadership seem to lend itself more toward advocacy initiatives.

Charismatic leaders.

The word “charisma” originates from the Greek word that means gift and was commonly used in the writing of the New Testament by Paul (Conger & Kanungo, 1987). The term is often used in social science to describe leaders whose personality traits and attributes allow them to amass followers who adopt their vision as they follow the leader toward a specific goal. These leaders have been responsible for significant social transformations and directives for action in
our society (Conger & Kanungo, 1987). The power or influence these leaders exhibit generally
does not emanate their position in society or their organizational affiliation. Kent (2001)
attributes the charismatic leader’s persuasive ability to their rhetorical ability to persuade,
influence, and mobilize others. It is generally the “gift” and the “value in the vision” that draws
followers to enlist their resources to make the dream a reality.

Political scientists and sociologists have attributed the following characteristics and traits
to charismatic leaders: transcendent vision or ideology, able to be trustworthy, acts of heroism,
rhetorical ability, and the ability to inspire and build confidence (Conger & Kanungo, 1987).
However, communication research indicates that the ability to be a credible communicator is
another key to be a successful advocate (Conger & Kanungo).

A charismatic leader is often seen as a type of social reformer as they work to promote
advocacy for a particular situation (Conger & Kanungo, 1987). These leaders are responsible for
transforming their followers and the situation at hand. They often seek for radical change as they
work toward their idealized goal. They are able to use their personal power and attributes to
manage advocacy for change.

Transformational leaders.

Transformational leadership occurs as the result of a purposeful exchange between the
leader and the follower (Kuhnert & Lewis, 1987; Kent, 2001). It is not based as much on the
compliance of followers, but relies more on the melding and exchange of ideas that shape both
the leader and the followers. This type of leadership represents a reciprocal exchange in which
both the leader and the followers gain something of value from each other.
Transformational leadership, like charismatic leadership comes from the personal values and beliefs of the leader. They both gain influence by demonstrating important personal qualities and attributes of integrity and justice (Kuhnert & Lewis, 1987). However, this type of leadership is not based on the almost “faith-like” adherence of followers. The transformational leadership has more of a tendency to “groom and develop” their followers.

Transformational leaders motivate their follower to accept and accomplish difficult goals that they normally would not have attempted. The followers in turn adapt to the internal standards of the leadership. This produces changes in attitude, beliefs and the goals of the followers. The end result is that the leaders and followers are changed (Kuhnert & Lewis, 1987).

Empowering grass roots leaders.

Minkler and Wallenstein (1997) defined community organization as the process by which community groups are assisted in identifying common problems or goals; mobilizing resources, or developing and implementing strategies for reaching their collective goal(s). Imbedded in this definition is the notion of empowerment of the community. Empowerment is a concept used by theorists to explain the effectiveness of an organization (Conger & Kanungo, 1988) in which individuals exercise more control over the decisions that influence their health and lives (Laverack & LaBonte, 2000). Consequently, empowerment gives individuals or organizations the opportunity to be “change agents” in the process being undertaken and therefore influence their own destinies.

In the strictest sense, community empowerment is a bottom-up process that occurs when individuals within the communities are intimately involved in the identification of a problem, the crafting of a strategy, and the development of the solution (Minkler & Wallenstein 1997; Laverack & LaBonte, 2000). This form of community participation was elevated with the 1986
adoption of the World Health Organization Healthy Cities Movement initiative and its participatory approach to health promotion (Minkler & Wallenstein, 1997). Ideally this process will identify community leaders who are activists at the grass roots level. Although grass roots leaders are often lacking official positions and titles, they are a vital part of defining community activism and working for the common goals of their community (W F Kellogg Foundation).

Rowitz (2001) challenges public health leaders to recognize that leading is an active, visioning process that requires the cultivation of deliberate skills. The debate has moved on from whether leaders are born or made. Leadership is a complex, multifaceted process that requires adherence to public health principles to be effective.

**Media Advocacy**

In this informational overload society, it is critical for public health advocates to be knowledgeable about the use of advocacy to explain their positions and shape public opinion. Walter Lippmann in 1922 defined mass media in this way. He said, “…(it is) like a beam of a searchlight that moves restlessly about, bringing one episode and then another out of the darkness into vision (Wallack, 1994). Chapman and Lupton (1994) describe media advocacy as being one of the main tenants of public health advocacy. Wallack (1994) defined media advocacy as the strategic use of media to pressure policy-makers to act.

Decision makers and their staffs routinely monitor news and print media to assist in the development of their position on issues. Therefore the successful waging of a media campaign is one of the most effective ways of gaining the attention of those who make decisions and influence public policy (American Public Health Association, 2009.).

Wallack (1994) also viewed media advocacy as a method to advance a social or public policy initiatives. It is based on the approaches that include social marketing, risk
communication, behavioral decision theory, and entertainment education (Mailbach and Holtgrave, 1995). Media Advocacy focuses on applying strategic pressure on key decision-makers through the media with the intent of bringing about changes to policies, regulations or legislation (Wallack & Dorfman, 1996),

Media campaigns are most commonly aimed at altering perceived social norms (Abroms & Maibach, 2008). They have had significantly powerful roles in shaping the behavior of individuals and populations. The most common use of media campaign advocacy is the ability of planners to craft and present their own message in their own terms to evoke change. This differs from traditional public health campaigns in that it gives “voice” to the issue being considered (Wallack, 1994).

Media advocacy also differs in that it targets the “power gap” in the message. Traditional public health messages address the “informational gap” of the targeted population (Wallack, 1994). The premise is that the presence of enough information will evoke changes in the individual or the situation. The information gap model promotes a “knowing of enough facts” to cause change in the individual or situation. It is assumed that when people have enough facts, they will act accordingly and change the resultant behavior. Media advocacy breaks with that tradition in that its focuses on the re-shifting and redesigning of the power to enable one to have the ability to define the problem, create the strategies, seize the opportunity, and make change happen (Wallack). A primary strategy of media advocacy is to work with individuals and organizations to claim the power of the media to actually change the context or environment in which the problem occurs.

Wallack (1994) describes media advocacy in terms of Lippmann’s classic three step model of mass media, “Step one involves” identifying of a situation or problem and bringing it
to the light”. This process is carried out through agenda setting. Step Two “holds the spotlight on the issue” and focuses the attention upstream. This is considered the framing of the event. The third step involved the actual development of the social or public initiatives as the primary approach to the issue.

Mailbach and Holtgrave (1995) describe advocates gaining access to the media as providing three key advantages:

1. Placing the public health issue on the public health agenda,
2. Framing and reframing the issue that places the advocacy position in a better spotlight than it might have otherwise been, and
3. Proposing specific social and policy decisions to actually solve the problem.

The Institute of Medicine issued numerous reports substantiating the power of media and communication in developing public health strategies (Abroms & Maibach, 2008). Therefore the successful waging of a media campaign is one of the most effective ways of gaining the attention of those who make decisions and influence public policy (American Public Health Association, 2009.). One of the most successful public health advocacy campaigns launched has centered on the changing of the public’s attitude concerning the use of tobacco.

**Advocacy In Action**

Australia’s second hand smoke campaign

Freeman, Chapman, and Storey (2007) reported on the Australia study which documented the advocacy case of exposing children to second hand smoke (SHS) while riding in the car with smoking adults. Strong scientific evidence purporting the dangers of second hand smoke (SHS) has been known to researchers for decades (Freeman et al., 2007; Chapman & Lupton, 1994). An Australia study in 1992, equated the interior air quality of a car with a
smoking adult to a smoky bar. This data fueled the 12 year advocacy campaign to ban smoking in cars carrying children (Freeman et al., 2007).

In 1995, the world’s first study demonstrating support for the ban against smoking in cars carrying children was reported. In a study of stories concerning Australians’ attitude about smoking in cars with children reported an 80% rate supporting some type of ban on the activity (Freeman et al., 2007). However the ban continued to languish in the court system due to the strength of the tobacco manufacturers and pro smoking lobby. Despite, multiple reports concerning this topic released through the years, it was the report that smoking was the State’s leading cause of preventable death that really pushed the issue to the forefront of news stories (Freeman et al., 2007). The Anti-Cancer Council supported a voluntary ban while the Victoriana Government ruled out the ban against smoking in cars. There were several small newsprint articles about the issue in subsequent years. Advocacy groups continued to push to get this issue resolved by legislation.

In July 2005, Action on Smoking and Health released a public opinion survey which indicated that 90% of Australians supported the ban (Freeman et al., 2007). In March 2007, the legislation was finally signed into law.

The passage of this law demonstrates the social justice issue which caused the banning of an action that had previously been viewed as a “private right” for the good of society-the health of unprotected children. This is also an example of where the framing of the situation from an individual right or behavior was refocused to the environment where the situation occurs (Dorfman et al., 2005). Advocacy organizations, over the twelve year period used newsprint to effectively sway public opinion. Eventually, the public support was so strong that it persuaded the government to institute the ban against smoking in cars when children under 18 are present.
North Carolina’s tobacco-free school policy.

Summerlin-Long, Goldstein, Davies and Shah (2009) reported on North Carolina’s efforts to pass a tobacco-free-school (TFS) policy. They were the first state in the US to develop a statewide mass media campaign to promote the adoption of a TFS policy. Advocates conducted interviews with over 45 TFS experts and legislators in order to craft an effective media campaign. These experts determined the test message and the images they believed most acceptable to the public. These themes were used to launch the TFS campaign that started in the fall of 2006. By August 2008, the North Carolina legislature had passed legislation that all schools would enforce a TSF policy.

Mass media campaigns are an important tool for changing and shaping individual behavior (Summerlin-Long et al., 2009; Chapman & Lupton, 1994). Media advocacy theory suggests that media campaigns impact public health and decision makers (Chapman & Lupton, 1994). The setting of the policy agenda at the start of the campaign is critical to its success (Summerlin-Long et al., 2009). The success of the initiative rests in the planning that precedes the development of the mass media strategy. The planners developed a clear and concise policy agenda. They used this information to develop and test television and print ads which were targeted to the designated population and policy makers. This targeted media approach was very successful in having TFS legislation signed into law.

This case study illustrates the power of a properly constructed mass media campaign to frame an issue. The advocates developed a clear and concise message with tested images and messages. They successfully used informants to frame their message and target the individuals who ultimately impact decision makers. The successfulness of this campaign indicates the importance of framing the idea into a structure amenable to constituents and policymakers.
Results

On January 8, 2007 Michigan signed PA 653 - Michigan’s Health Disparity Research and Education Act into law to address the disparate health outcomes for minority populations (State of Michigan, 2007). Multiple statistics from the MDCH continue to point to the inequities that exist for minority populations in all racial/ethnic minority groups from the cradle to the grave (Michigan Department of Community Health, 2007). In some instances, the difference in disease rates is increasing in the face of MDCH’s effort to address these concerns. The HDRMHS, MDCH’s coordinating body assigned to address health disparities is inadequately funded and does not have an allocated line item in the Michigan General Fund Budget. Over 61% of their revenue emanates from the HMF - the state’s discretionary funding stream - which was cut 13% in the last budget allocation (Michigan League for Human Services, 2009). Almost all of the state’s prevention and disparity programs are funded through the HMF. The decrease of funding for the HMF removes one of society’s safety nets for those who can afford it. One of the few ways to stop this assault on Michigan’s minority citizens will be the enactment and enforcement of PA 653 - Michigan’s Health Disparity Research and Education Act. However, a targeted and effective advocacy campaign is needed to inform the public of the plight of minority citizens; the economic impact of health disparities on Michigan; and why they should even care. It is only then that decision makers will move to make PA 653 more than just a law on the books.

Public health advocacy is an issue and policy-orientated process whereby the social determinants of health that impact health disparities can be addressed. It must be rooted in a clear and concise message that educates the general public and instills a reason to care about the issue. The social justice message has to be established as the basis of providing for the overall good for all of Michigan’s citizenry in addressing this problem. Working to solve health
disparities for minority citizens will be of benefit to all of the public. The targets of this
campaign must address the broader issues of the social determinants of health that fuel these
inequities.

The actual framing of the advocacy campaign is most critical to the public perception of
the message. It must begin with a clear statement of the problem and the requisite action the
public or decision maker needs to make. The advocates must also develop strategies that
carefully evaluate the strengths and weaknesses of both the advocates and their opposition. The
use of experts in the field to craft images and sound bites for public consumption concerning this
issue would also enable the supporters of this advocacy campaign to “put their best foot
forward”.

The development of a strategic plan for the public health advocacy campaign is the basis
of the effective strategy. The identification of an overall goal is the key component for
developing a concise and effective plan. The plan requires the consideration of the problem,
possible solutions, and identification of key sources of support and how to get the attention of the
decision makers. Although there are several models for developing advocacy campaigns, most
of them revolve around answering key questions.

Charismatic, transformational and grass-roots leaders are some of the leadership styles
that can successfully navigate an advocacy campaign. Sometimes a leader will emerge from the
community in which the problem exists. In other instances, a mandate from the affected groups
will select a leader. The most important qualities of a successful leader include trust and vision
because these traits fortify the relationship between followers and the leader.

Individuals involved in an advocacy campaign must understand the use of mass media to
achieve their goals. The general public and decision maker routinely monitor news print and
internet sources as they develop positions and attitudes about an issue. Given the constant barrage of media to our senses, it is very important to understand how to effectively “make the case” for the issue of interest to media sources.

Conclusions and Recommendations

The APHA Advocacy Model clearly lays out a strategy which should be utilized in the development of an advocacy campaign for PA 653. The public health advocacy campaign must craft a strategy that clearly delineates what advocates expect from full implementation of the PA 653. According to the APHA model there are four questions that must be addressed;

1. What is the problem (s) being highlighted?

The first problem is that there are health disparities in that state of Michigan that lead to death and sickness in minority populations and socially and financially impact to the state. An additional underpinning to the main problem is that PA 653, that was designed to address health disparities, is not fully implemented or funded. The HDRMHS, the section charged with implementation of the law lacks the funding, infrastructure, and possibly the intent to successfully implement PA 653.

2. Is there a solution to it? If so, what is it?

PA 653 contains the several solutions for addressing health disparities.

The first mandate of the law is for HDRMHS to develop a strategic plan to address health disparities. It is often said that you cannot reach your destination without a plan for arriving there. Development of the strategic plan is a critical first step in this process.

The law also states that HDRMHS should partner with minority coalitions in the state. HDRMHS has identified several minority coalition and minority groups across the state already
working in this area (ASTHO State Heath Agency Survey, 2007). These organizations have a vested interested in solving the disparate health outcomes for minority populations. An invitation should be extended from the advocacy group leading the charge to other minority organizations in Michigan to form a statewide coalition to address this issue. The leaders of the individual organizations in the coalition would form the steering committee that would manage the advocacy campaign. The fact that these organizational leaders already are involved in minority health issues and have extensive knowledge as to the conditions in their communities would enable them to test the messages and images of the campaign.

There needs to be a public health advocacy campaign to fully implement and financially support PA 653. In these difficult financial times, the state would most likely have to reallocate funds currently being used for another purpose to this one. Advocacy groups and health organizations are all rallying for public support and “circling the wagons” on their line item. Consequently, finding dollars in this environment is indeed challenging and might require the identification of external sources and nontraditional alliances. The intent of the public health advocacy campaign is to compellingly frame the issues to garner public support. Once public sentiment is cemented in support of this legislation and the issue it addresses, legislators would be motivated to fund and implement the law.

The financial state of Michigan’s economy would most certainly mandate the infusion of external funds in this process. Advocates would seek nontraditional alliances with businesses and strengthen current relationships with federal and state agencies and philanthropic organizations to provide funding for the public health advocacy campaign. The successful use of framing the issue in the social justice concepts of inclusion, benefits for the public good and appeals to the altruistic nature and economic benefits to Michigan’s citizens would have to be a
part of the language and images depicted for the campaign. It must be grounded in the context of a “win-win” for all citizens.

The last two questions are combined because of the similarity of the response. These questions are:

3. Whose support do you need to gain in order to make the solution happen, and
4. What needs to be done do or said to get the attention of those who can make the solution happen?

A successful advocacy campaign for PA 653 begins with ideological support of the public and ends with the legislative and MDCH decision makers.

The legislature would be the ultimate target of the public health advocacy campaign since the legislature determines the budget allocations for the entire state and MDCH in particular. If the legislature is convinced that their constituency deems an issue pertaining to minority health and the implementation of PA653 important-then they will act accordingly. However, their intention starts with an informed electorate that views these as important issues for the State to consider.

In these very difficult financial times in the State, there are numerous competing interests and forces for the allocation of dollars in the state budget. An old adage says, the squeaky wheel gets the oil”. Advocates for ending health disparities must speak loudly to be heard against the backdrop of falling revenues and rising health care expenses. The impending and inevitable economic impact of health disparities on Michigan is probably the only message that will resonate during this fiscal downturn. This “voice” must be the leading message seen in newsprint, spoken about on talk shows, and displayed in images in the advocacy campaign.
Another problem the advocates face in developing the public advocacy campaign is the general lack of knowledge about health disparities in general and PA 653 in particular. That will require advocates informing minority and majority citizen about impact of health disparities on Michigan. The intent is that once both populations realize the impact of health disparities on Michigan’s citizens that their concern will assist advocates in changing the apathy within the legislature regarding this issue. Basically, the advocacy campaign must address the benefits that will be accrued to each community if the issue of health disparity is addressed by fully implementing PA 653.

LaVeist, Gaskin, and Richard (2009) have already proven that health disparities impact the financial health of the nation. Given the current depressed economic climate which is consuming Michigan, the most compelling message to convey to the general public is that “Unattended health disparities will increase overall health care costs and ultimately threaten the state’s economic viability.” Advocates must prove that the current health outcomes impacting minority populations will have a detrimental effect on the health of the state as a whole. Citizens have the choice to either continue to ignore chronically ill individuals in minority populations that financially impact the health care system or become proactive and try to stem the tide of costs associated with the disparate health outcomes of Michigan’s minority citizens.

One critical limitation of the study is the dearth of information as to the actual cost of health disparities to the state Michigan. Studies are just being released nationally as to the impact of the health disparity within minority populations. At this point, Michigan can best measure the cost in terms of increased rates of sickness, premature deaths, and loss of productivity. Analysis of these costs will aid the development of the public advocacy campaign.
The Michigan legislature was compelled to sign PA 653 into law with bipartisan support in the Michigan House and Senate in 2006. An effective public health advocacy campaigns seeks to garner similar support to change PA 653 from a law on the books to full implementation.
References


