working upstream

skills for social change

working upstream

skills for social change

a resource guide for developing a course on advocacy for public health

developed by

Lori Dorfman
Berkeley Media Studies Group
Public Health Institute

Susan Sorenson
School of Social Policy & Practice
University of Pennsylvania

Lawrence Wallack
College of Urban & Public Affairs
Portland State University

supported by a grant from The California Endowment

table of contents

acknowledgements

This work is dedicated to the memory of Ruth Roemer, a tireless advocate for the health of the public.

We would like to thank The California Endowment for understanding the need for this work, as well as for their financial and conceptual support. Barbara Masters and Gigi Barsoum, in particular, contributed to the success of this work.

We express our appreciation to faculty members E. Richard Brown, David Dyjack, Vicki Ebin, John Elder, Stephanie Farquhar, Ralph Frerichs, John Froines, Mary Beth Love, Edward Mamary, David Michaels, Meredith Minkler, Sara Rosenbaum, Darleen Schuster, Harry Snyder, Jack Thompson, James Trussell, and William Vega, for their contributions during the initial meeting for this project.

Thanks to the public health students attending, and graduates of, the public health programs at California State University, Northridge; Loma Linda University; San Diego State University; San Francisco State University; San Jose State University; University of California, Berkeley; University of California, Los Angeles; and the University of Southern California, for offering their thoughts about how advocacy is — or isn't — discussed in their programs.

Thanks to advocates Mark Chekal-Bain, Larry Cohen, Donna Garske, Stefan Harvey, Kirsten Moore, Mark Pertschuk, Kathleen Rest, Susan West-Marmagas, Dan Wohlfeiler, Anthony Wright, and Ellen Wu, for their contributions during the second meeting for this project.

Thanks to the reviewers for their cogent comments. In addition to the faculty and advocates mentioned above, we

thank Elizabeth Burke Bryant, Carol Kamin, Justin Louie, and Makani Themba-Nixon who gave us valuable feedback on various lessons.

This work is a collaborative effort among Susan Sorenson, Lori Dorfman, Lawrence Wallack, and Sonja Herbert. Joining the collaboration were Sara Rosenbaum, who authored the lesson on Policy Analysis, Harry Snyder, who authored the lesson on Policy Advocacy with assistance from Tanecia Echols and Nadia Campbell, Vivian Chávez, who authored the lesson on Community Organizing, Larry Cohen, Kate Pastor, and Sana Chehimi, who authored the lesson on Coalition Building, Julia Coffman, who authored the lesson on Evaluating Advocacy, and Stephanie Farquhar and Nancy Cuilwik, who authored the Note on Service Learning. Katie Woodruff and Liana Winett edited the Vignettes and Lessons from Public Health Advocacy. The Vignettes drew on lessons from Larry Cohen, Stephanie Farquhar, Donna Garske, Sonja Herbert, Kristen Moore, Mark Pertschuk, Liana Winett, and Ellen Wu; we thank them for sharing their stories. Julia Marcus and Jaimie Morse provided research assistance in the early stages of the project. Photographs in Lesson 5 were taken by Susan Duerksen.

Special thanks to Steve Teret, whose conversations over the years with Lawrence Wallack provided the impetus for our efforts.

preface

During the last few years, The California Endowment has placed increased focus on policy and advocacy work. We believe that for many societal challenges, creating policy change can have a more systemic and lasting effect on improving the health of Californians. And, we have seen the success of this strategy. We have supported advocates to bring to light many public health problems, and real change has resulted — from banning sodas in schools to improving access to interpretation services in the health care setting for people who don't speak English. However, we know that continued success depends on having a large cadre sophisticated advocates that can effectively navigate the challenging terrain of policy advocacy.

To answer this need, The California Endowment developed advocacy training programs for our grantees delivered through the Health ExChange Academy by our Center for Healthy Communities. That training series is helping practitioners and community leaders across California become active on local, state, and national policy.

Still, there was more to do. Policy leaders advocating for change on our most difficult issues — health care, asthma, obesity prevention, and more — needed reinforcements. A logical place to look was to the public health programs in the state's universities, since they are training the very people who will staff the organizations seeking to create healthier communities in California.

Public health programs train masters degree students for positions in community-based organizations and government agencies. The programs tend to focus on research and intervention but generally lack systematic training for students in policy advocacy despite the fact that advocacy is a central strategy in translating science into public policy.

The Resource Guide you now hold is a first step toward addressing that educational need.

The process Berkeley Media Studies Group and their colleagues used to develop the Resource Guide drew on public health faculty and advocates from California and across the nation. They have devised a comprehensive yet flexible compendium of course work that can be adapted in public health programs everywhere.

We look forward to seeing these materials used to prepare public health students for the escalating challenges they will face in advocating for the policies that will bring health to every population in California.

Barbara Masters
Gigi Barsoum
Public Policy Department
The California Endowment
February 2009

"The key challenge facing public health education today is reconciliation of the academic environment in which most public health education takes place with the practice environment for which students are destined."

KM Gebbie, L Rosenstock, LM Hernandez
Who Will Keep The Public Healthy?
Washington, DC: National Academies Press, 2003

background

Degree-granting public health programs typically focus educational efforts on research and practice. Considerable resources are invested in creating competent consumers and producers of research. Course offerings and internships also emphasize practice, including program planning, health education, and policy. However, the connection between research and practice is sometimes not as well developed or fully articulated in academia as are research and practice, alone.

Public health needs more practitioners who can bridge the gap between research and practice, people who can take research findings and use them to inform policymakers and influence the development and implementation of policy. Public health students need to understand the process of social change and, when indicated, be able to advocate for social change.

Unfortunately, many public health faculty do not possess the skills or experience to teach advocacy effectively. Faculty surveys show, for example, that despite advocacy for health being recognized as an ethical responsibility and required competency of health educators, many health education faculty do not see themselves as competent for teaching advocacy and lack instructional materials to do so (see Radius et al 2009). Degree-granting programs in public health need to provide systematic training in social advocacy. In the absence of formal training in social change, public health graduates must learn this information and develop these skills on a catch-as-catch-can basis. Working in this way means that some will be less effective than they otherwise could be in advancing the health of the public.

Our objective in developing this resource guide is to provide tools and examples to help public health faculty instill skills in their students for working upstream where, by doing advocacy, they can improve the environments that cause unnecessary morbidity and mortality.

the current project

Process

In recognition of this curricular gap, present in many universities that educate students in public health, we enlisted the participation of faculty from across the nation, as well as that of leaders in nonprofit public health organizations and current students and recent graduates from several degree-granting public health programs and schools, in order to develop this resource guide. To recount briefly, we:

Reviewed existing courses on social advocacy in public health programs. Through an online search and additional information provided by multiple instructors, we found that about half of the universities (20 of 42) surveyed nationally offer one or more relevant courses. After obtaining and reviewing the syllabi for 28 of the 29 currently offered courses, we concluded that only a handful of courses emphasized skills-building, and even fewer emphasized the skills necessary to participate in advocacy for social change.

Obtained input from faculty members representing a range of perspectives and disciplines. We convened a meeting of faculty who have significant experience in, and commitment to, social advocacy. Faculty emphasized the importance of conceptualizing "advocate" as both a verb and a noun in public health. In other words, it is not just what one *becomes* but what one *does*. They identified knowledge, skills, and real-life experiences that are essential to educate public health students about social change. They also identified techniques that can be used to teach the knowledge and skills with which to create upstream change. Further, faculty noted tensions regarding the definition of advocacy; the role of educational institutions in teaching social change; and the perceived need for, and associated institutional and professional career barriers to, a course on social change. Finally, they noted the importance of making social advocacy respected course content, while also acknowledging the friction that seems to be widespread at universities between research and advocacy.

Obtained input from public health graduates. Through surveys of, and focus groups with, students and recent graduates of California schools, we learned that although few graduates identified themselves as advocates, most reported engaging in some form of advocacy-oriented work as part of their regular jobs. Graduates reported that, with a few

exceptions, the topics of social change and advocacy were not well integrated into the curriculum where they earned their degrees. They suggested various topics, skills, and teaching methods for a course on public health advocacy, most of which are included in this training manual.

Obtained input from leading advocates representing organizations around the country, working on a range of public health issues. We convened a meeting of individuals from advocacy organizations and government agencies, a group that represented those who have hired or might hire public health graduates. The advocates indicated that graduates must understand an ecological perspective of public health problems, be familiar with the tactics needed to make goals happen, and know how to build social movements. They pointed to the importance of both knowledge and passion in successfully addressing public health issues. They also emphasized the importance of real-world understanding and experience (e.g., having worked in communities) for students learning about public health advocacy. Advocates observed that faculty in institutions of higher education often hold values that reflect U.S. cultural norms emphasizing individual responsibility for solving health problems, rather than collective responsibility. They noted that public health graduates are not comfortable with confrontation, taking unpopular positions, or advocating for the use of the police powers of public health. Moreover, they asserted, public health graduates often are unable to "get to the heart of it" when analyzing an issue. Advocates also indicated that public health education does not adequately build skills that would fall under the category of "leadership development."

Synthesized information and drafted materials. We synthesized information from the above-listed activities, drafted training materials that were reviewed by both faculty and advocates, and revised accordingly.

products

Based on this process, we developed the educational lessons that are contained in this resource guide. These lessons address key topics that can help public health students learn how to work upstream addressing the environments that create disease, injury, and premature death.

These lessons were designed to be flexible. We encourage faculty to use whatever lesson, or parts of a lesson, that best meets their needs. For example, instructors may take parts of the lessons that they find relevant and add them to existing courses. Faculty also may combine lessons, perhaps with additional content the instructor wants to include, in order to create a new free-standing course.

Each lesson contains:

- A synopsis of the topic
- Learning objectives
- Slide text with elaborations of key substantive points
- Discussion questions
- Skills-building exercises
- Student assignments
- Suggested guest speakers
- List of required readings
- List of supplemental readings
- Web-based resources

Finally, appendices include vignettes that can be used to illustrate advocacy concepts and a synopsis of the role of service learning in furthering student knowledge about social advocacy.

conclusion

Social advocacy is central to the mission of public health and a significant responsibility for public health professionals. Through focused instruction and experiential learning, faculty can help public health graduates meet that responsibility.

These lessons will supplement, but not supplant, faculty effort in designing and implementing a course. We hope this manual will be a useful tool for those who want to increase in their courses the emphasis on upstream approaches.

references

Gebbie KM, Rosenstock L, Hernandez LM. *Who Will Keep The Public Healthy?* Washington, D.C.: National Academies Press, 2003.

Radius, SM, Galer-Unti, RA, Tappe, MK. Educating for Advocacy: Recommendations for Professional Preparation and Development Based on a Needs and Capacity Assessment of Health Education Faculty. *Health Promotion Practice* 10(1): 83-91, January 2009.

1

Concept and Mission of PH

introduction

The field of public health is where the major social, political, economic, and cultural forces of our society all collide in an effort to improve health. Public health seeks to create an environment in which people can be healthy, which involves the often contentious process of blending science, politics, and activism in the context of social values and interests. Indeed, this process requires navigating along the nerve centers of society. As might be expected, raw or exposed nerves are frequently touched and unpleasant shocks result. Health care reform, gun control, limits on alcohol and tobacco, HIV/AIDS prevention, and family planning (to name just a few) have touched more than a few such raw nerves. Each of these shocks is a reminder that virtually every public health issue is a microcosm for the larger debates in our society. The practice of public health is, to a large degree, the process of redesigning society as if health were the primary goal. This is something, however, on which there is not agreement among the larger populous.

This lesson explains public health as a broader systems approach rather than a more reductionist exercise focused on individuals, their behavior, and their biology. In so doing, this lesson draws on CEA Winslow's classic definition of public health, the work of Dan Beauchamp, and the contributions of Geoffrey Rose to establish the foundations of public health and some of the key elements that form the basis for the public health profession.

The mission of public health, as put forth in the classic 1988 IOM report, *The Future of Public Health*, is a comprehensive and socially aggressive view. The IOM argued that

the mission of public health is prevention. This lesson elaborates on that mission by explaining the upstream/downstream metaphor, exploring resistance to moving toward an upstream approach, and discussing the values that provide the basis for the upstream approach. Following on the work of Dan Beauchamp, this lesson describes social justice as the guiding ethic of public health, and suggests that the ethic of market justice has become stronger over time, making the pursuit of public health more difficult. Finally, this lesson offers a basic set of criteria that can be considered when difficult ethical decisions must be made regarding public health approaches.

learning objectives

By the end of this lesson and completion of all assignments, students will be able to describe the importance of social change and advocacy for achieving the overall goals of public health.

Specifically, this will include:

1. The definition and mission of public health
2. The role of the upstream metaphor
3. The nature of "blaming the victim"
4. The principle of social justice as a guiding ethic

key points to be made in lesson

1 IOM mission of public health

The definition of public health, the principles that underlie it, and the functions that it subsumes all grow from its mission. The classic statement of this mission is taken from the 1988 Institute of Medicine report, *The Future of Public Health*. A quick read will miss the significance of this statement, but it harkens back to both Virchow and Winslow: "assuring conditions in which people can be healthy." This is a very broad and very ambitious point. *[Instructor: Ask students to discuss what they think these conditions might be and what it means to "assure" them.]* Given the expansive recent research on the relationship between social inequality and health inequality, as well as our increasing understanding about the root causes of health disparities, we are required to consider justice, fairness, equal opportunity, and other basic social structural issues as part of those "conditions in which people can be healthy."

Mission of public health

The mission of public health is to fulfill society's interest in assuring conditions in which people can be healthy.

Its aim is to generate organized community efforts to address the public interest in health by applying scientific & technical knowledge to prevent disease and promote health.

The Future of Public Health
Institute of Medicine Report, 1988

2 Cartoon of a doctor coming out of an ICU and telling the wife of an apparently deceased man, "I was able to get in one last lecture on diet and health."

This cartoon reflects the very strong public health orientation toward "lifestyle" education. Within public health many leading thinkers have emphasized the importance of looking at the contexts within which individual behavior takes place. Yet, particularly in the US, with its heavy emphasis on individualism, public health has often had a default mode of moving toward "lifestyle" education. Obviously this is not all public health does, but it does seem that considerable effort goes into getting people to "just behave better." Strategies are focused less on changing the social and political environments in which people exist, but rather on changing people to better resist the perils that seem to be embedded in their environments. There is undoubtedly an extremely strong belief in the power of information. It is the idea that if we just get the right message, to the right people, in the right way, at the right time, they will change their behavior. Unfortunately, it does not work that way often enough. Behavior is enormously complex and cannot be separated from the broader social, cultural, economic, and political contexts in which it exists.

3 Three fundamental lessons about public health education, public policy, and the importance of participation

We know that education about health behaviors is extremely important. However, we also know that while this type of education is frequently necessary, it is not sufficient for improving the health of populations. This is sometimes difficult for people to understand because we have such a strong faith in the importance of education. But understanding the benefits and limits of health education as a specific public health strategy is vital to an appreciation of the overall importance of advocacy in public health.

Policies are important because they change the contexts for individual decision-making. For example, policies limiting unhealthy foods in schools increase the likelihood that students will be more exposed to choices promoting healthy eating, and less exposed to choices reinforcing health-compromising behaviors. Such policies could help us create an environment in which the conditions that support health were more common, and the conditions that contributed to higher levels of disease less pervasive.

Finally, there is a growing body of work beginning to address the issue of community participation. This relates to the research process as reflected not only in community-based participatory research, but in the policy-making process as well. The growing literatures on social capital, civic participation, and democracy have significant implications for public health.

Key public health points

Education may be necessary but it is not sufficient to promote the health of populations.

Policies that govern the conditions that give rise to and sustain public health problems are essential to developing healthy communities.

Participation in the democratic process itself may contribute to a sense of power and be important for health.

4 Core concepts of public health covered in this lesson

There are, of course, a wide range of concepts important for the public health profession. For the purposes of this course, we will be focusing on those that are more socially oriented.

Core concepts for course

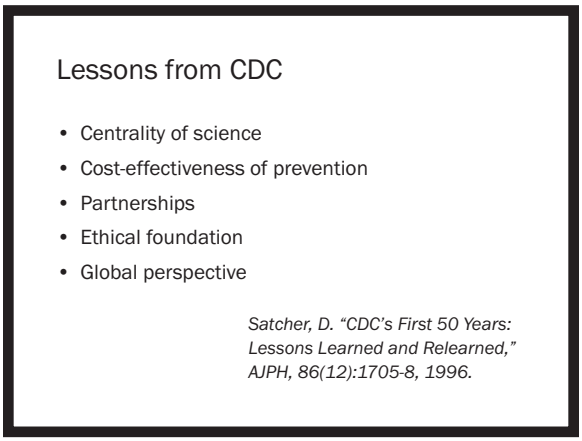
- Individualism
- Social justice/market justice
- Population/high risk
- Prevention paradox
- Blending science, politics, advocacy
- Blaming the victim
- Social gradient

5 Functions of public health

Each of these functions has research as its base but also feeds advocacy. Assessment and surveillance are about identifying problems and monitoring them over time, how they progress, or how they are limited in various settings and populations. This function helps to tell us what things we should be concerned about. Without adequate research in this area there can be no credibility or legitimacy for moving ahead to the next step: policy development, or where we say what we can do about the problem. Thus, the stronger the research base, the more aggressively we can make the case for action. Finally, we need to know whether the solutions that were proposed (i.e., the policies and programs developed) were fully implemented in the manner in which they were intended, and whether they made the difference we thought they would. This is the assurance function. Research again emerges as essential for moving forward as we refine our strategy, monitor implementation, assess the actual impact on the problem, and advance in a way that is firmly rooted in a research process.

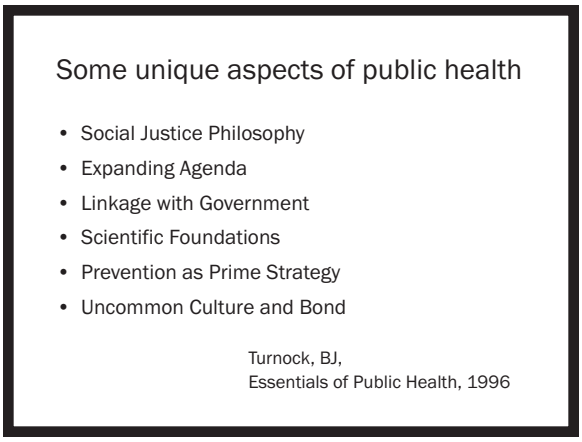
6 Summary of lessons from the first 50 years of the CDC

When David Satcher was CDC Director, he summarized five of the most important lessons from the first 50 years of public health. Scientific excellence, he argued, is vital for the success of public health, such as the development new data technologies that allow us to identify outbreaks that would otherwise go undetected. Population-based prevention strategies, such as smallpox immunization, are the most cost-effective investment we can make in public health and ultimately save us the money we would have to spend on medical treatment. Public health is most successful when we cultivate partnerships with the private sector, community-based organizations, and between domestic and international bodies. Beyond a strong scientific foundation, public health must also be guided by certain principles, ethics, and values, such as the respect for all individuals across racial, gender, religious, sexual, ethnic, and geographic lines. Finally, public health must maintain a global approach, with a concern for the health of all human beings on the planet; "disease," Satcher wrote, "knows no borders."



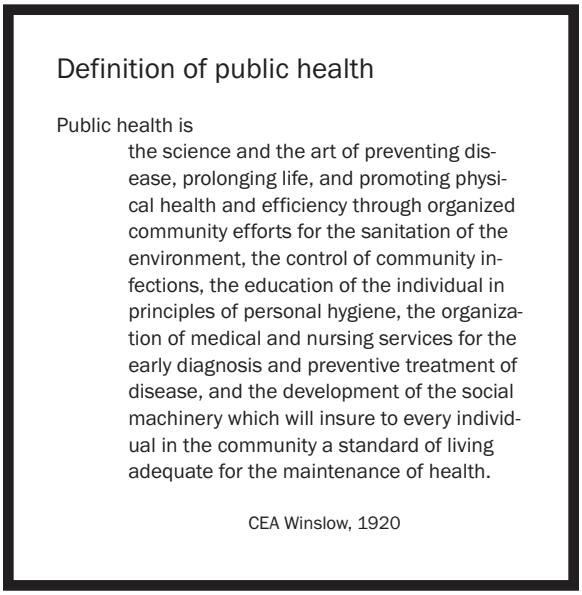
7 The unique aspects of public health according to B. Turnock

Turnock builds on Dr. Satcher's observations. Of particular note is the specific reference to social justice and the idea of an expanding agenda. Public health always seems to be pushing its own boundaries. For example, it was only in the 1990s that violence gained substantial attention as a "public health issue." Prior to that time it was widely regarded as within the purview of criminal justice.



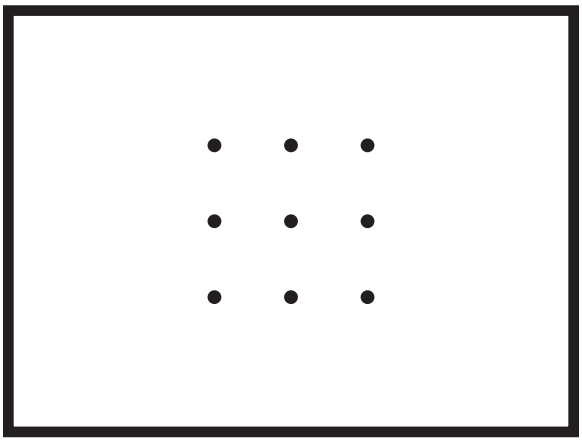
8 Winslow's definition of public health

This is sometimes referred to as the world's longest sentence. So what is public health, anyway? How do we define it? As you might expect, there are many definitions of public health, great and small, and we argue about these a lot because how we define something has many implications for what we do about it. One of the most famous, lasting, and longest, definitions is by CEA Winslow, an early 20th-century public health leader and Yale professor. This definition is notable for its comprehensiveness, as well as for its vision. Note that it suggests a broad social scope in its reference to the "development of the social machinery which will insure to every individual in the community a standard of living adequate for the maintenance of health."



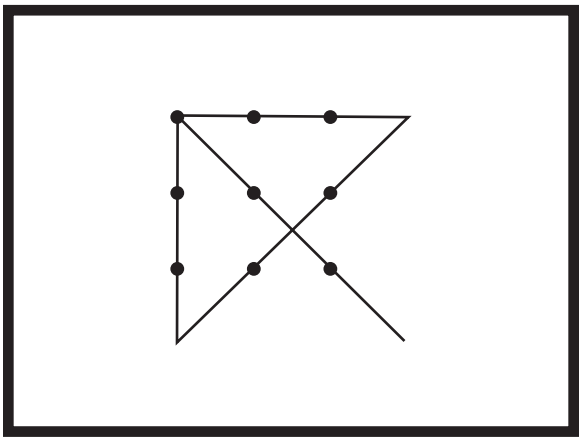
9 The nine dots exercise

[Instructor: Use this exercise to illustrate how our prior assumptions can constrain us from solving problems. The task here is to connect the nine dots by drawing four straight lines, without the pen or pencil leaving the paper. Ask students to make at least one effort to do this. Emphasize the need to connect the nine dots with four straight *lines.*



10 The nine dots exercise solution

Usually about 10% of a large group will find the solution. Often someone will say, "But you didn't say we could go outside of the box!" The point here is that there is not a box, just nine dots. The "box" represents an assumption that people make. As long as people assume that the dots represent a box, the problem cannot be solved. It is only by not having any prior assumptions, or by questioning the assumptions one does have, that a person can solve the problem.] Questioning assumptions is an important aspect of understanding public health.



11 Chart using drugs as an example that shows the importance of problem definition

Using the example of illicit drugs illustrates that there are various ways that a problem can be defined. There are always competing views of a public health problem because there is so much at stake. How a problem is defined will determine the range of legitimate solutions that might be applied. Something that is primarily defined as a medical problem will be addressed using a set of approaches that are primarily medical. This is not to say that other approaches are not used, but merely that the primary, and dominant, approaches will be medical in nature. Criminal justice approaches, for example, will still be present but will not be the primary focal point for intervention.

Perspectives on drugs

primary perspective	view of person	treatment responsibility	solution
medical	sick	health care	treat, educate
legal	criminal	courts & law enforcement	incarcerate, punish, deter
moral	ignorant, weak, or sinful	family, schools, religion	educate, exhortate, stigmatize
social economic	victim	society	make system more just & equitable
public health	integral part of larger system	shared	multi-level devel & coord of prevention policy & programs

The notion of problem definition is extremely important because dollars follow definitions, as well as solutions those definitions legitimize. More funding for treatment programs might mean less funding for drug interdiction or community-based prevention programs. Problem definitions also generally suggest a moral judgment. Medicalization of an issue like drug abuse or alcoholism, for example, will reduce the moral stigma that might be associated with those behaviors. Therefore, it is quite understandable that the arguments about how a problem is defined can be extremely contentious.

12 Second problem definition example

This is a specific example, again using drugs, that shows how the level of solution will follow from the level at which the problem is defined. As a profession, even when public health defines *problems* on a socio-structural level, there still is a tendency to define *solutions* on an individual level. This is a mismatch that leads to programs that might be safe and non-controversial, but which are also generally ineffective.

Defining the problem

problem	lack of Information	Lack of resources & alternatives
approach/solution	information from media and parents	Increase social resources
target for change	potential drug user, drug user, family, schools,	governing & corporate bodies that control resources
group to be mobilized	media and parents	community groups

13 The nature of public health as a political process: Rudolf Virchow quote

There should be no doubt that public health is a very political undertaking. Certainly, science must be at the core of the profession, but so must be social change. This awareness of the importance of social change runs very long and deep in public health history. This quote by Rudolf Virchow, as well as the story behind it, is a classic touch point for public health and preventive medicine. The story is that Virchow, the founder of cellular pathology and also of social medicine, was sent to Upper Silesa in 1848 to study a typhus outbreak. He reported back to the Berlin Council that had sent him that social factors — such as lack of education, housing, and sanitation — were at the root of the epidemic, rather than strictly medical causes. There are various interpretations of what the Virchow quote means, but public health historian George Rosen has provided three points that can guide our thinking:

- Social and economic conditions profoundly imÏpact health and disease.
- The health of the population is a matter of social concern, and society has an obligation to protect the health of its members.
- Steps to combat disease must be social as well as individual.

Origins of social medicine

"Medicine is a social science and politics is nothing but medicine on a grand scale."

Rudolf Virchow

14 Public health tensions: Paul Starr quote

Indeed, the history of public health is one of tension. Paul Starr's book, *The Social Transformation of American Medicine*, provides a very good, quick overview of this tension. Again thinking back to the importance of problem definition, there is much at stake in controlling whether something is seen as a personal-individual-behavioral problem or as a social-political-economic one. There is always conflict among the various positions because the winners have their values upheld and are able to channel funding into areas that support those values. As such, their positions in society are strengthened. Research is, of course, very important. However, it ends up that it is only one variable among several, and the empirical-rationalist appeal that it might have for us as educators may not extend to other groups. In sum, scientific research alone is simply not sufficient to resolve the big questions regarding what we do about significant public health issues. As Martin Rein, the public policy scholar, reminds us, "The crucial issues in a policy debate are not so much matters of fact as questions of interpretation." Certainly, many important matters in public health that might largely have been resolved with existing research have been delayed for years, and even decades, because of underlying value conflicts. Needle exchange, tobacco, and environmental issues are just a few areas in which such delay can be seen.

Public health tensions

Much of the history of public health is a record of struggles over the limits of its mandate. On one frontier, public health authorities have met opposition from religious groups and others with moral objections to state intervention....On another frontier, public health has met opposition from business and commerce, anxious to protect their economic interests.

Paul Starr
The Social Transformation of American Medicine

15 The "basic question for public health"

This question poses the balance of individual and structural approaches to improving the public's health. The issue here is not either/or but the need to find some balance between the focus on personal behavior and social change. This is a constant tension, and something that not only is at the core of public health and other social services but at the very nature of our society. In considering what kinds of strategies and interventions we pursue, we should reflect on the question of whether improvements in the public's health will come about *primarily* as a result of people getting more information about their personal health behaviors, or groups getting more skills to influence the policy process and change social and economic conditions. It seems that most public health people believe the latter but focus most of their activities on the former. This is really a great public health paradox. For many it means that we believe one thing, but then work on strategies and activities that do not fully apply. *[Instructor: Ask students to discuss why this is so.]* Why is this the case? Certainly there are many contributing factors, such

Basic question for public health

Will improved population health status come about primarily as a result of:

individuals getting more knowledge about personal health behaviors?

or

groups getting more power to change social and economic conditions?

as the disease-by-disease categorical nature of funding, the reinforcing nature of focusing on immediate short-term issues, the emphasis on randomized controlled trials and individual-level interventions, and our own professional training. But much of this really comes down to the contexts in which we operate. And such context is heavily influenced by the strong American ethic of individualism, often driving the kinds of interventions we choose to implement.

16 Representation of *upstream-downstream* story

The profession of public health has a dominant metaphor that helps to explain the overall vision for the field. This is the upstream-downstream story.

There is a public health person standing on the banks of a river, along with two other people. All of a sudden, there is a cry for help as someone comes floating down the river, clearly drowning. As the public health person pulls the drowning person out of the river and resuscitates him, one of the other people standing on the river bank is yelling, "What's wrong with you, why can't you swim?" Meanwhile, the second person on the bank is offering discount coupons for swimming lessons.

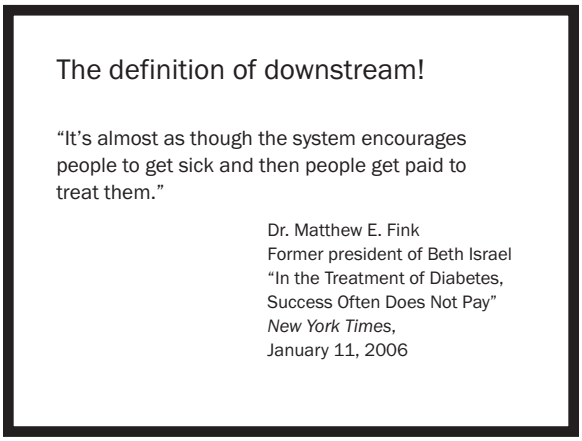
It is tough at the river, because more and more people come floating down and it is not possible to pull them all out. Also, some who get pulled out find themselves back in the river. Moreover, it is expensive to pull people out, but it is necessary, and always will be. However, merely pulling folks out of the river will never eliminate the problem because more and more new people keep falling in, and the root causes for falling still remain.

As more victims, more researchers, more community members, and more public health people congregate around the river and start sharing their perspectives, the more different perspectives are discussed, and the more insight develops.

Finally, a critical mass develops and a group of people decide to head upstream and see what is causing so many people to fall in. They find colorful, clever signs with messages tempting people into the river: "Jump in – the water's great!" They decide to start painting over the billboards and challenging the laws that allowed the signs to be posted, thus shaping the environment to make it more conducive to keeping people out of the water. They also find a remarkably high level of social and economic inequality that means some people live perilously close to the riverbank while others are protected, living at distance from the worst dangers. They realize that this also contributes to the ultimate downstream public health toll. This is the core mission of public health: moving further upstream to better identify root causes, as well as the policies that might productively address such causes. It is about moving toward prevention and creating those "conditions in which people can be healthy."

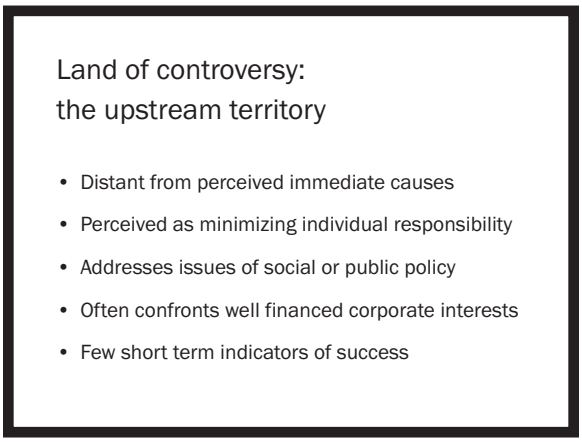
17 Quote illustrating downstream nature of our society

"It's almost as though the system encourages people to get sick and then people get paid to treat them." This is a quote regarding the growing incidence of diabetes, and the failure to address food-related policies that are fueling the epidemic. However, it could have been about tobacco, alcohol, or even motor vehicles.



18 Why the upstream territory is controversial

Going upstream is what public health is all about. Shifting attention to reducing the conditions that give rise to, and sustain, disease — and starting to promote the conditions that give rise to, and sustain, health — is fundamental to prevention. Still, the upstream territory is fairly controversial for a number of reasons. Also, it can be difficult for some people to augment their roles as providers of direct service to support upstream work.



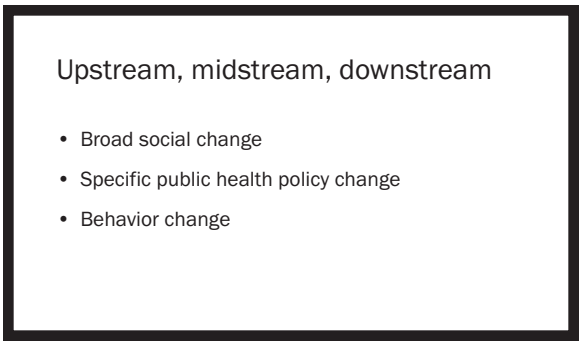
We live in a "downstream" society. As we move upstream and get closer to the root causes of the problem, we find that it gets to be *more* political, *more* controversial, and *less* scientific from a traditional view, while also becoming *more* contentious. Specifically, it becomes more:

- *Political*, because we begin to confront powerful vested interests (e.g., food producers, alcohol and tobacco industries, gun lobbyists, the prison industry).
- *Controversial,* because we start to move away from the standard way that people think about health and social behavior in our society (that health is simply a matter of individual choice).
- *Less scientific*, because the distance between cause and effect becomes greater. For example, teen pregnancy can be primarily understood as an effect of lack of knowledge about birth control, or as a response to a lack of opportunity, hopelessness, and lack of community infrastructure. One view suggests a relatively simple solution, the other a much greater level of complexity.

19 Dividing the river between social change, policy change, and individual change

Think for a bit about the kinds of policies that might be useful to structure the upstream environment. It is useful in considering this to reflect on the appeal made by Nancy Milio, UNC Chapel Hill Professor of Public Health: We need to create an environment where health promoting choices are easier to make and health damaging choices are more difficult. And, we need an environment in which the conditions that helped create health are more common, and conditions that contributed to higher levels of disease are diminished. The question is, how could we reorganize our society?

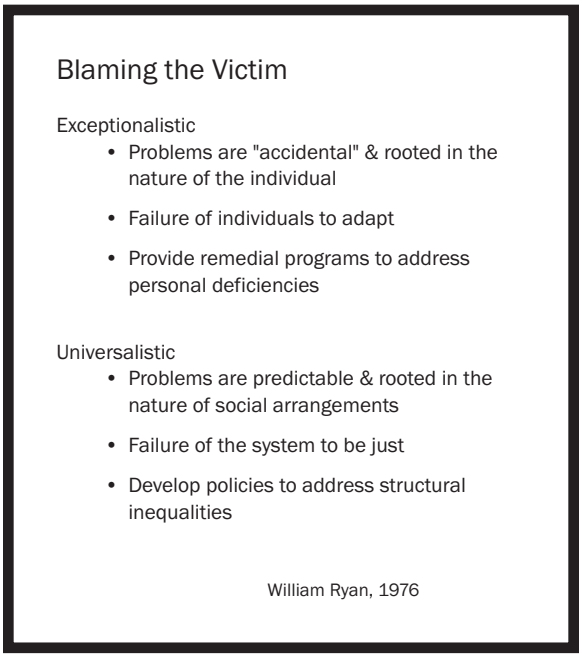
Think about some of the leading contributors to premature death and disability in our society, including tobacco, food, and alcohol: What are some examples of upstream policies? Try going beyond what people commonly consider to be the social inequality/health inequality connection. What do some of the upstream policies look like when addressing these contributors from that perspective?



20 Blaming the victim: Exceptionalistic vs. universalistic

Take a moment to consider what is meant by "victim blaming." This is a concept developed by sociologist William Ryan to examine not only how we understand problems, but also the implications of this way of understanding.

Individualism is certainly a good thing. However, hyper-individualism can quickly become part of the problem rather than part of the solution. There are many constructive critiques of individualism, but perhaps one that is most basic to public health is Ryan's classic, *Blaming the Victim*. In essence, Ryan's argument is that we can understand social, and by extension health, problems in one of two ways. First, they can be seen as "exceptionalistic," meaning that problems are accidental and rooted in an individual's failure to adapt to the system. Solutions offered through this understanding would include remedial programs that help the individual better adapt by providing him/her with either more information or more skills. Second, according to Ryan, problems can be seen as "universalis-



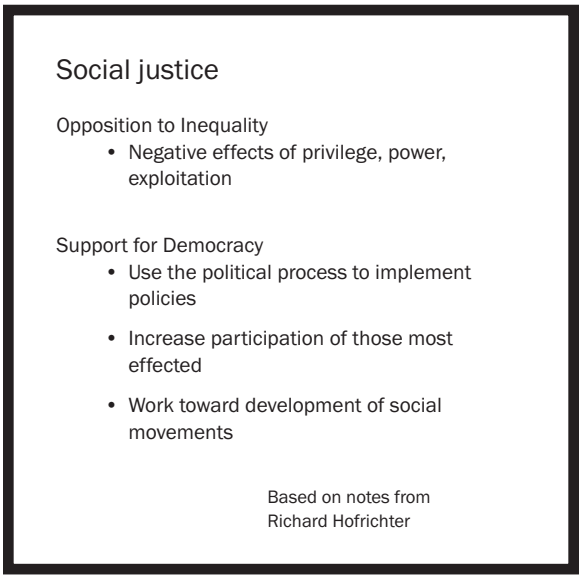
tic," meaning that they can be predicted because they are products of the way we organize our society. In other words, problems are not accidental, but probabilistic: they are more likely to happen to members of one group than another. In this case, failure lies not in an individual's lack of adaptation, but in the system's ability to be fair and just. Solutions offered through this understanding would include policies that address the inequalities built into the system. The current debate over how to address health disparities follow along these lines. It is the first of these two alternative understandings that Ryan has called "blaming the victim," because individuals are held uniquely responsible for the adverse effects of systemic conditions.

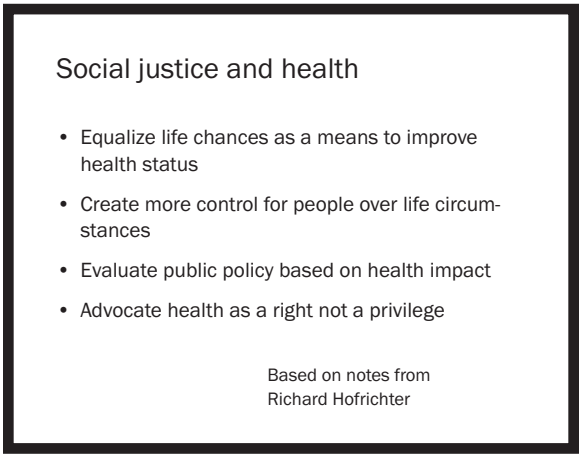
On a deeper level, "blaming the victim" allows us to believe that we are in control of our destinies by reinforcing the notion of personal responsibility. It serves as a moral lesson, as well as a rationalization for the bad things that happen. It reinforces the sense that there are reasons why these things happen, and that these explanations are best applied at the individual level.

21–22

Operationalizing social justice

It is difficult to find a definition of social justice that will gain widespread agreement. Richard Hofrichter, however, provides us with two clear points that resonate both with public health and a pragmatic streak that runs deep in our society. The first is opposition to inequality and the value of fairness. The second is support for democracy and the use of participatory approaches that allow people to use the power that the democratic process allows. Specific objectives follow from these two general points that form the basis for using public policy as a means for increasing fairness in order to improve health status.





23–25

Basic elements of social justice/market justice

One of the greatest resources regarding the intersection of public health and social justice has been the work of Dan Beauchamp (pronounced "Beechum"), and in particular, his paper entitled "Public Health as Social Justice." Beauchamp's basic argument is that *social justice* is the underlying ethic of public health, while at the same time, *market justice* represents the greatest barrier to public health effectively pursuing its mission. If anything has happened in the decades since Beauchamp wrote his paper, it is that the hold of market justice on our society has only become stronger. To a great extent, these perspectives also mirror the thinking of Ryan in his work on blaming the victim. In a nutshell, social justice is a good fit with public health because it argues for shared responsibility, the urgency of prevention, the important role of government, a strong obligation to the collective good, and the well-being of the community over the individual. Market justice, on the other hand, focuses on self-determination, limited role of government, and a limited obligation to the collective good. The pursuit of self-interest, as unfettered as possible by the government, is the guiding principle of the market justice orientation. Social justice argues, in contrast, that we are all in this together.

How can we apply a concept as vast as social justice? John Rawls wrote a classic book called *A Theory of Justice*. In it he talks about justice as fairness. How, then, do we think about justice? He suggests we select the principles of justice from an original position in which there are no preexisting rules, and from behind a veil of ignorance where we do not know our social status. This is an interesting thought experiment. Imagine that you do not know whether you would be born rich or poor, white or a person of color, man or woman. Imagine you do not know whether you would be born a citizen of Japan, with the world's longest life expectancy; the United States; or Sierra Leone, in which the life expectancy is only 26 years. Imagine you do not know whether you will have all of your physical and mental capabilities, only a few of them, or none at all. Nor do you know whether you were born into the wealthiest neighborhood, or the poorest. Then imagine, given this veil of ignorance,

Basic elements of market justice

- Self–determination
- Rugged individualism
- Benefits based solely on effort
- Limited obligation to collective good
- Neutrality of major social institutions
- Voluntary nature of behavior
- Limited government intervention

Basic elements of social justice

- Shared responsibility
- Strong obligation to collective good
- Unequal starting positions require attention
- Focus on social conditions
- Benefits assured
- Community well-being supercedes individual well-being
- Government involvement necessary

Market justice concepts

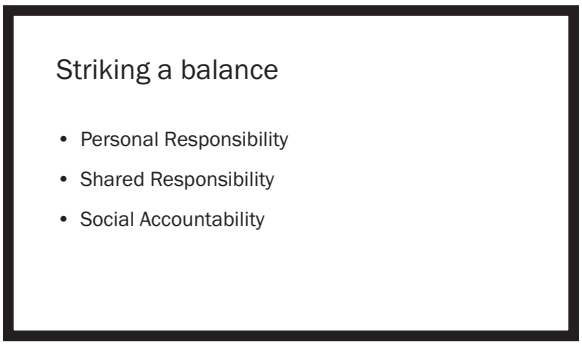
Market-justice is the primary roadblock to dramatic reductions in preventable injury and death. More than this, market-justice is a pervasive ideology protecting the most powerful or the most numerous from the burdens of collective action.

Dan Beauchamp, 1976
"Public Health as Social Justice"

how you would select guiding principles for society that you think are fair. Also consider how you would design policies governing the economy, jobs, globalization, education, health, housing, and social programs. What would you want the rules of society to be if you did not know where and how you would begin? How level would you want the playing field to be?

26 Striking a balance between personal responsibility and social accountability

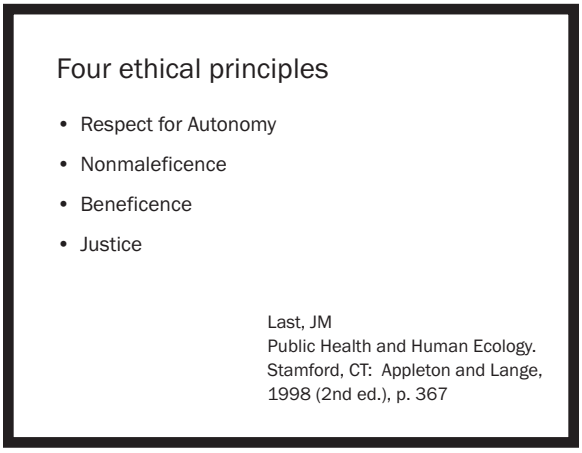
In our country, there is a continuing public discussion about the right balance between social justice and market justice, and between the responsibility of the individual and the broader concept of social accountability. What we try to do is strike a balance among personal responsibility, shared responsibility, and social accountability. This is an ongoing debate in our society, and there is certainly no one "right" viewpoint. Historically, however, public health has worked to tip the scales more toward social justice, and has struggled against market forces in order to make this happen.



Another way to think about this is the balance between individual *responsibility* and community *response-ability* for health. Meredith Minkler defines response-ability as "the capacity of individuals and communities to build on their strengths and respond to their personal needs and the challenges posed by the environment." She argues that public health must work toward an approach that promotes healthy environments by stressing both individual responsibility and broader community action to increase "response-ability."

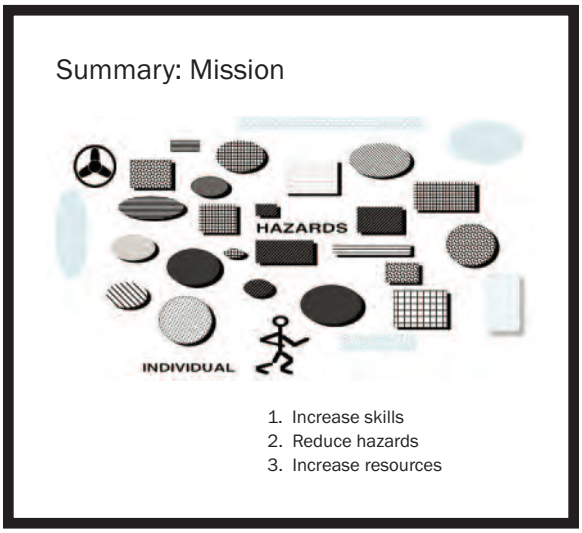
27 Last's four ethical principles

Another aspect of structuring the discussion around the right balance between social justice and market justice is to consider John Last's four ethical principles. This leads us to assess overall strategy and specific policies, using the following questions: Does the activity show respect for autonomy? Does it do no harm? Does it actually result in some good? And finally, does it further the interests of justice or fairness? *[Instructor: Ask students to consider the mandatory use of motorcycle helmets for some good insight into these questions, particularly on the issue of autonomy, but surprisingly on the other questions as well. Another good example to discuss is fluoridation of the public water supply.]*



28 Summary

This is a graphic representation of the public health mission. Generally, the approach has been to provide individuals with information, education, or in some cases, specific skills. The implication is that if the proper advice is followed, an individual will be able to navigate the hazardous health environment. The upstream approach, however, suggests that removing hazards in the environment will increase the likelihood that an individual will be successful in his/her pursuit of health. Hazards can be broadly, or narrowly, defined, ranging from controls on the availability of alcoholic beverages to the marketing of cigarettes; the control of menus in school lunchrooms; or the requirement that motorcyclists wear helmets. Further upstream, there are policies that might alter some of the social determinants of health cutting across many health problems. Thus, broadly speaking, the issues of living wages for workers, child care, affordable housing, Head Start, etc., might provide ways to increase the levels of resources available to individuals that, in combination with increasing skills and removing hazards, would improve the public's health. All three of these areas suggest potential for policy advocacy.



discussion questions

A While sitting in the hallway waiting for class to begin, the president of our university spots you and asks how your class is going. You say, "Fine," and he responds, "What is public health anyway?" You carefully explain….

B You are out on a fishing trip with your friends. One of them happens to say, "Let's go upstream and see if the fish are biting any better up there." You say, "Upstream? That reminds me of the mission of public health. Let me tell you about it while we are walking." You go on to explain….

C You come to work with a cast on your arm, and your boss asks you what happened. You tell her that you were playing with your kids at the playground and fell off the jungle gym. She says, "You should have been more careful." You, slightly embarrassed and hurt, respond, "You should not blame the victim." She says, "What are you talking about?" You patiently explain to her….

D Your father-in-law just quit smoking and thinks the tobacco company that made his brand should pay him for the lung disorder he claims is due to his having smoked for many years. You say smoking is a personal choice, and people should be left free to do so if they choose with full acceptance of the consequences. He says, "No way; the cigarette companies exploited me, and profited by getting me to compromise my health. This is a matter of social justice!" What is he talking about?

E You run into an old college friend who asks you what you are up to these days. You tell her that you are an aspiring public health professional. She says, "You mean one of those people who are always telling others what is best for them, as if they are too stupid to make up their own minds?" You respond, "Yeah, that's right." She says, "Cool, how do you decide on the difficult ethical questions involved in interfering with other people like that?" You go on to tell her….

skills-building exercise

"Pin the Intervention on the Stream"

The objective of this exercise is to help participants understand where solutions to various public health problems fit on the continuum of individual-oriented solutions that aim to change personal health behavior (i.e., downstream), to environment-oriented solutions, often policies, which aim to change the social or physical environments in which personal health decisions are made (i.e., upstream). Students discover that both upstream and downstream solutions are necessary, and that depending on the emphasis any given intervention might apply upstream or downstream, but that usually it is harder to move an intervention upstream.

To conduct this exercise, ask students to work in small groups. Each member of the group should describe a public health intervention s/he knows. Then the group should help identify and write on an index card:

1. The goal:
   What was the intervention supposed to do? If your approach is successful, what change will occur?

2. The target:
   Who or what is the intervention aiming to change? Are there primary or secondary targets?

3. The activity:
   What happens when the intervention is implemented? How is it carried out?

When everyone in the group has described an intervention on an index card, the group should go to the "stream" drawn on the board, identified with "upstream" and "downstream" regions, and decide where to tape their cards.

After the small groups have finished their work, the whole class should reconvene to discuss the placement of interventions on the stream. Ask the participants for their general reflections about the exercise. Was it easy to figure out where to put the intervention? Did the members of the group always agree? Next, assess the stream: Where are most of the interventions, upstream or downstream? Why does the group think the pattern looks as it does? Would it be different for different issues? Is there a way to get some of the downstream interventions to move upstream? Is that a useful idea?

assignments

1 The local public health department is being attacked for what its critics call a paternalistic and intrusive government approach to the work. In the last year, the department has worked with various community coalitions to get vending machines out of schools, limit alcohol availability in neighborhood markets, and support a fee on home sales in order to build affordable housing. The city council, which controls funding for the health department, has asked the director to justify working on these issues. The director has hired you as a consultant to help get through this crisis. She needs you to write a five-page paper that provides a clear rationale, explaining why these kinds of activities constitute good public health practice rooted in a clear set of values.

2 The local television news, as limited as it is, is a primary source of information for many people in the community. Watch at least six hours of local news on various stations. Provide an analysis of what you think people are learning about health, and more specifically, about public health, from this source of news. Try watching during dinnertime and count health-related advertisements compared to advertisements for other products. Who do they appeal to and what are they telling the viewer to think about and do? As you conduct your analysis, be aware that sometimes what is left out of the news is as important as what is in the news. What do you learn? Limit your analysis to five pages.

possible guest speakers

- Public health department director, or other leaders of public health interventions
- State or local health officer
- Public health leaders of policy campaigns
- Community health advocates who work at the population level
- Legislators concerned about health disparities
- Epidemiologists studying the social determinants of health

required reading

Beauchamp D. Public Health as Social Justice. *Inquiry*, XIII (March):3-14. 1976.

Gordon L. Public Health is More Important Than Health Care. *Journal of Public Health Policy*, 15(3):261-264. 1993.

Green L. Letter to the Editor. *Health Education Quarterly*, 14(1): 3-5.1987.

Mann J. Medicine and Public Health, Ethics and Human Rights. *Hastings Center Report* (pp. 6-13). May-June, 1977.

Minkler M. Personal Responsibility for Health: A Review of the Arguments and the Evidence at Century's End. *American Journal of Public Health*, 26(1):121-140. 1999.

Tesh S. *Hidden Arguments: Political Ideology and Disease Prevention Policy.* Rutgers University Press: New Jersey. 1998.

Wallack L. Letter to the Editor. *Health Education Quarterly*, 14(4): 383-5. 1987.

Wallack L, and Lawrence, R. Talking about Public Health: Developing America's Second Language. *American Journal of Public Health*, 95(4):567-570. 2005.

Will G. No One is Responsible for Anything (Op ed). *San Francisco Chronicle*, A25. July 7, 1998.

suggested reading

Barry B. *Why Social Justice Matters*. Polity Press: Cambridge, UK. 2005.

Bayer R, Gostin LO, Jennings B, and Steinbock B (Eds). *Public Health Ethics: Theory, Policy, and Practice*. Oxford University Press: New York. 2006

Dawson A, and Verweij M (Eds). *Ethics, Prevention, and Public Health*. Oxford University Press: New York. 2007.

Fink M. In the Treatment of Diabetes, Success Often Does Not Pay. *New York Times*. January 11, 2006.

Gebbie KM, Rosenstock L, and Hernandez LM. *Who Will Keep The Public Healthy?* National Academies Press: Washington, D.C. 2003.

Hofrichter R (Ed). *Health and Social Justice: Politics, Ideology, and Inequity in the Distribution of Disease*. Jossey-Bass: San Francisco. 2003.

Institute of Medicine. *The Future of Public Health*. Institute of Medicine: Washington, DC. 1988.

Last J. *Public Health and Human Ecology*. Appleton and Lange: Stamford, CT (2nd ed.). 1998.

Milio N. *Promoting Health through Public Policy.* F.A. Davis Company: Philadelphia. 1981.

Rawls J. *A Theory of Justice*. Harvard University Press: Cambridge, MA. 1971.

Rein M. *Social Science and Public Policy*. Penguin: New York. 1976.

Rosen G. *A History of Public Health*. Johns Hopkins University Press: Baltimore. 1993.

Ryan W. *Blaming the Victim*. Vintage Books: New York. 1976.

Satcher D. CDC's First 50 Years: Lessons Learned and Relearned. *American Journal of Public Health*, 86(12):1705-8. 1996.

Starr P. *The Social Transformation of American Medicine.* Basic Books: New York, 1982.

Turnock BJ. *Essentials of Public Health*. Jones and Bartlett. 1996.

Virchow R. The Charity Physician, Medizinische Reform 1848; No. 18, November 3. In Virchow, R. (1848/1985). *Collected Essays on Public Health and Epidemiology*. Cambridge, UK: Science History Publications, p. 33.

Winslow CEA. The Untilled Fields of Public Health. *Science*, 51:30. 1920.

other resources

American Public Health Association
http://apha.org/

Association of State and Territorial Health Officials
http://astho.org/

Centers for Disease Control and Prevention
http://cdc.gov/

Institute of Medicine
http://www.iom.edu/

National Association of City and County Health Officials
http://naccho.org/

2

Population Health and Health Determinants

introduction

One of the concepts that differentiates public health from the medical profession is the idea of population health. There are many different ways of thinking about this, but one interesting perspective was provided by a recent US Surgeon General. He used the metaphor of a forest, and explained that medicine is really about treating the sick trees so they could become disease-free. Public health, on the other hand, is about cultivating the soil and other conditions in the forest so that trees can be healthy. Sometimes medicine cannot understand the forest for the trees. Similarly, sometimes public health cannot appreciate the trees because of the greater forest.

While this metaphor may be an oversimplification, the general point is a useful one: Public health is about ensuring the conditions in which people can be healthy, and this requires a focus on populations rather than individuals. It means that public health understands illness and disease as consequences of social, economic, and political arrangements, not just at a personal, individual, and behavioral level.

It is useful to consider Geoffrey Rose's point, "A population strategy of prevention is necessary whenever risk is widely diffused through the whole population."

learning objectives

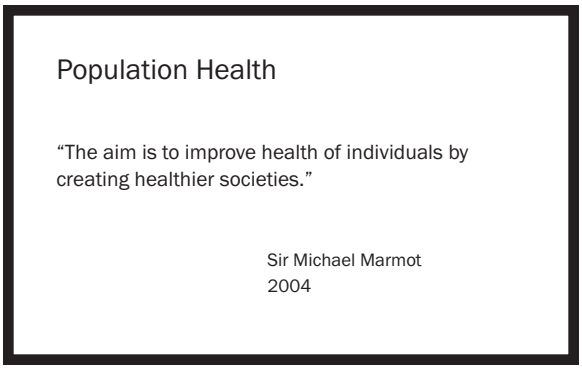
By the end of this lesson and completion of all assignments, students will be able to specify the importance of social change and advocacy to achieving the overall goals of public health. Specifically, this will include:

1. A population-based approach to public health
2. The prevention paradox
3. The nature of the social gradient
4. The roles of advocacy and public policy in pursuing public health goals.

key points to be made in lesson

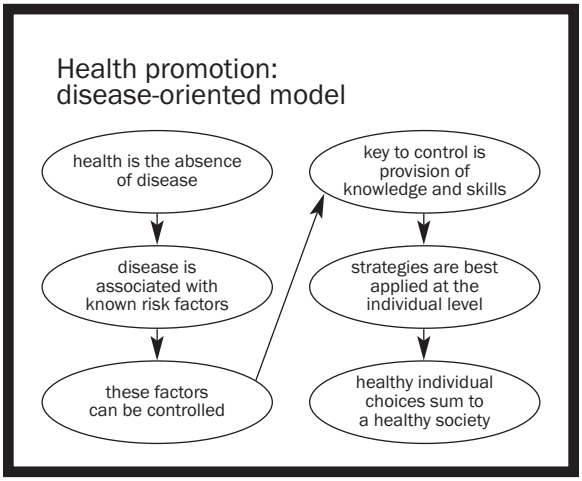
1 Population health

Population health can perhaps best be captured through this quote by Sir Michael Marmot. It is quite provocative, raising the issue of what constitutes a "healthy society," as well as what it would look like from an organizational perspective. Further, it raises the question of whether this organization bypasses, in some way, the role of individuals. After all, if every individual lived a healthy lifestyle, wouldn't that add up to a healthy society?



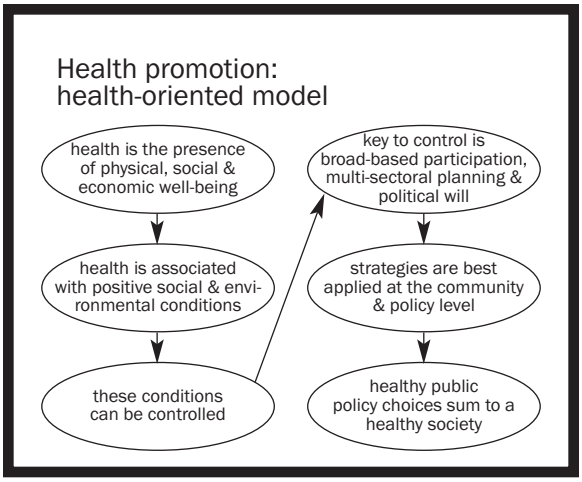
2 Logic of a disease-oriented personal view

The logic here is a fairly narrow, reductionist approach that seeks to understand public health problems by reducing them to individual-level variables. In this case, the focus is on identifying and controlling risk factors at the individual level and developing strategies to alter personal health behavior. The logic is that if we could just get every individual to make healthy choices we would create a healthy society. Work by many noted epidemiologists, such as Len Syme and John McKinlay, have provided a compelling argument as to why this approach has limited value.



3 Logic of a health-oriented population view

The logic of this health-oriented, or population, model is much broader and more synthetic. It understands health not as the absence of disease, but in a more comprehensive way: as the presence of certain social and economic conditions. This is consistent with the World Health Organization (WHO) definition of health, and a broader focus on populations. The emphasis is not on risk factors, but rather on these broader social and economic conditions. WHO calls for broad-based participation that cuts across the various levels of society, along with the realization that



these problems require political will in order to make progress. Strategies, rather than being applied at the individual level, are targeted at the community and larger society. Ultimately, the view here is that a healthy society is the product of the choices we make *as* a society, rather than the ones that we make as individuals.

This reflects back to our discussion of social justice principles and values (see Lesson 1).

4 Goals of a population approach

In order for the population approach to reach these goals it must be successful in controlling the underlying determinants of poor health. This relates back to social justice, and the concept that it is how we organize our society through public policy that shapes the nature and distribution of disease. It also reminds us about the broad mission of public health put forth by the Institute of Medicine, which focused on "assuring conditions in which people can be healthy."

Population-based approach

The goals of a population health approach are to:

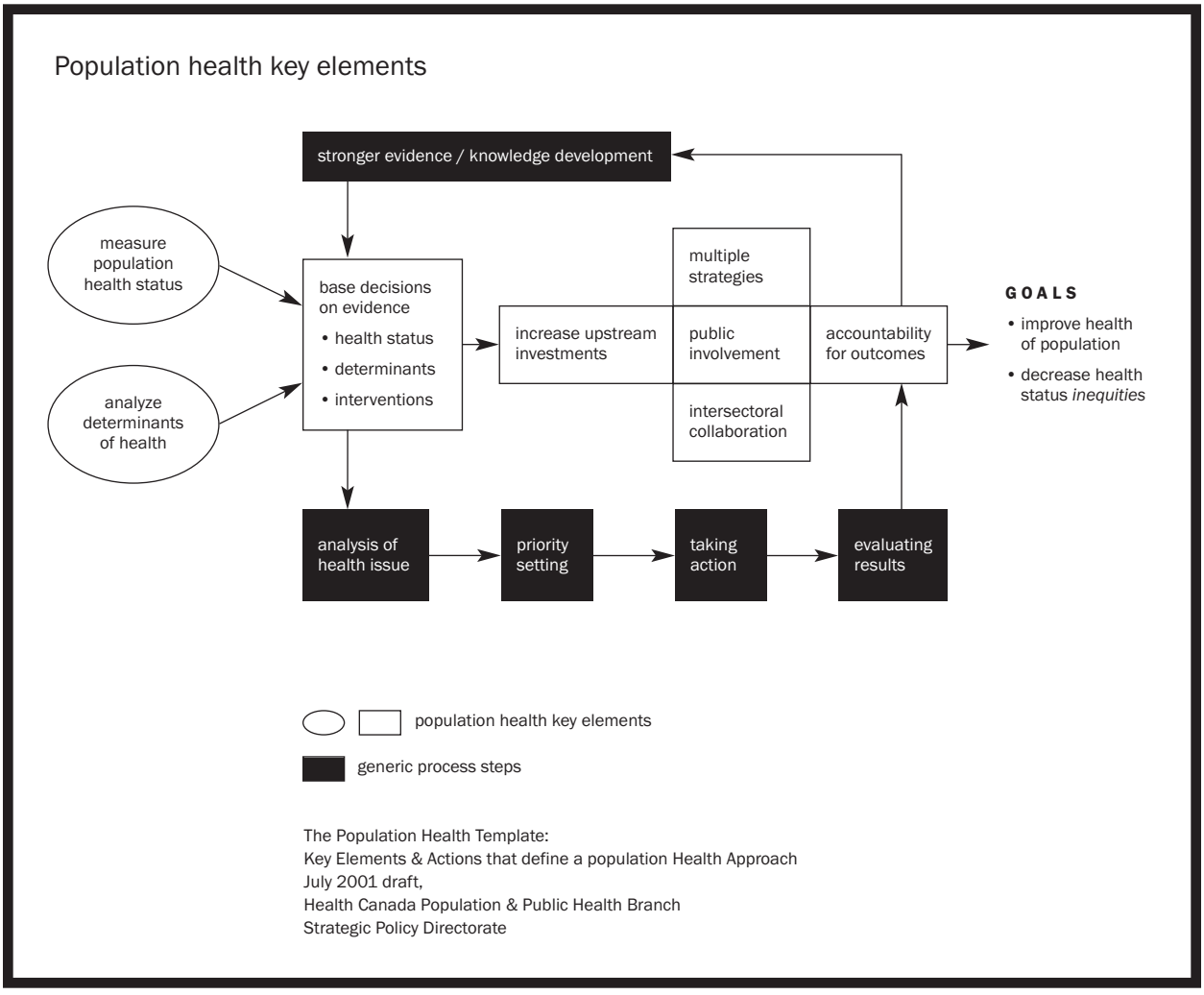
- Maintain and improve the health status of entire populations
- Reduce inequities in health status between population groups

The Population Health Template: Key Elements and Actions that Define a Population Health Approach, Health Canada, July 2001 Draft

5 Key elements of a population-based approach

The key elements include:

1. Focus on the health of populations;
2. Address the determinants of health and their interactions;
3. Base decisions on evidence;
4. Increase upstream investments;
5. Apply multiple strategies;
6. Collaborate across sectors and levels;
7. Employ mechanisms for public involvement; and
8. Demonstrate accountability for health outcomes.



6 Logic for the population approach: Population and high-risk analysis

The best resource for understanding the theoretical and empirical underpinnings of the population approach can be found in the work of Geoffrey Rose. He points out that there are certainly cases in which a focus on high-risk populations is appropriate. However, he also argues persuasively that it is necessary to control the underlying determinants of ill health in order to reduce population incidence rates. In effect, he argues that it is reaching the many around the middle of the distribution and at small risk that will yield the biggest results. The primary point is that while you are more likely to find disease in high-risk populations, the vast amount of disease exists in the much larger populations where the risk is lower. Or, as Rose says, "a large number of people exposed to a small risk may generate many more cases than a small number exposed to a high risk."

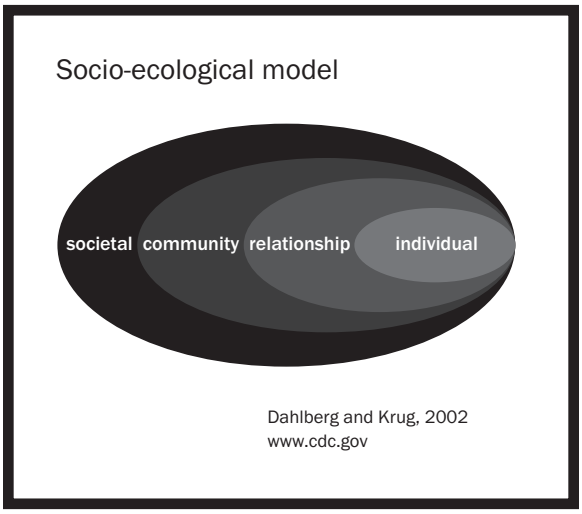
The example provided is constructed to make the simple point about how the numbers add up on this issue. Keep in mind that the population approach, with a focus on policy interventions, is more likely to permanently alter the environment in which people make choices. In effect, it changes the "upstream territory," rather than working down river.

Population and high risk analysis

Lower risk	**Higher risk**
900,000 people	100,000 people
10% risk of disease equals 90,000 cases	50% risk of disease equals 50,000 cases
(50% intervention success) 45,000 cases "cured"	(75% intervention success) 37,500 cases "cured"
(10% intervention success) 9,000 cases "cured"	(10% intervention success) 5,000 cases "cured"

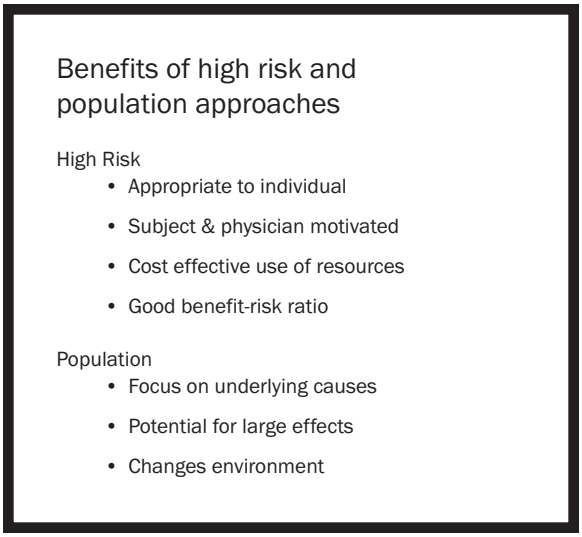
7 The socio-ecological model of public health

The Institute of Medicine stresses that public health professionals must be able to look beyond individual, biological risk factors for disease to focus on how environments affect health. The IOM calls this population approach the "ecological model," which it defines as "a model of health that emphasizes the linkages and relationships among multiple factors (or determinants) affecting health." This framework provides a conceptual basis for understanding the relationships between determinants of health. Individuals are embedded within societies and populations; environments can contribute to health outcomes through many different pathways, from individual lifestyle and behavior to access to resources. The ecological model helps us consider how public health can intervene on multiple levels (e.g., individual, neighborhood, and community) to improve health outcomes.



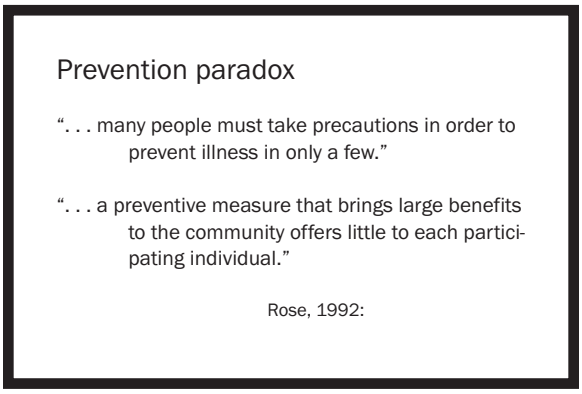
8 Benefits of different approaches

There are clear benefits to each approach, and there is no doubt that our society must use both. Again, as Rose notes, "preventive medicine must embrace both [approaches], but of the two, power resides with the population strategy."



9 Prevention paradox

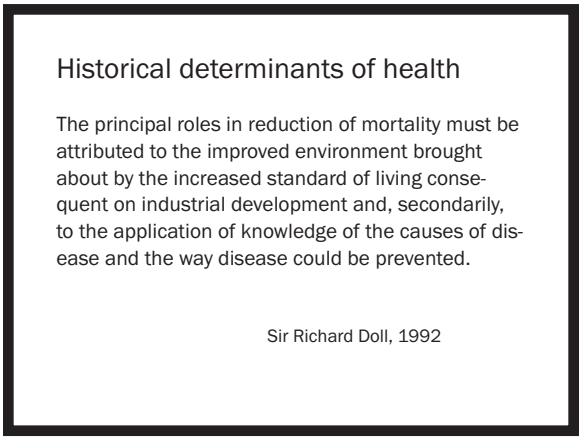
One reason the upstream, or population/prevention, approach is difficult can be seen in the formulation of the prevention paradox. The paradox is that a large number of people in a population who are at low risk may actually contribute more cases of disease than the few high-risk people. Rose used Down's syndrome as an example of this phenomenon. Younger mothers under age 30 are individually at much lower risk for Down's syndrome babies than mothers over age forty. However, the low-risk women generate half the cases because there are so many more mothers in that age group.

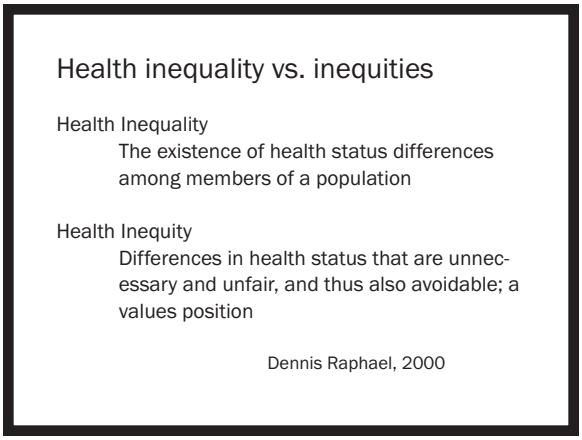


10–14

Determinants of health: Historical, inequality vs. inequities, social class, Syme quote, Wilkinson & Marmot quote

Over the past decade or so, there has been a substantial amount of research focused on the social determinants of health. This work draws upon the distinction between health "inequality," or differences in health status that exist among and across members of populations, and "inequity," or those differences that are based in inherent injustice and which are — by their very nature — avoidable. Some of the motivation for this work grew out of the development of social epidemiology and its focus on social class as a risk factor. This was largely due to the work of Michael Marmot and the Whitehall study, which looked at the relationship between social class and health. It was also due to Leonard Syme's work focusing attention on the limits of behavioral interventions and the importance of the social environment. Each built on a longer-standing history-of-medicine perspective, indicating that medical measures had contributed far less to advances in health status than had been popularly





thought. Thomas McKeown credits increasing longevity and better health "not to intervention in the working of the machine, but to improvement in the conditions under which it operates." This is a perspective shared by some other medical historians, as well.

It is important to note that there is a gradient of risk when it comes to social class and health. It is not a rich-poor dichotomy. This is extremely important for the concept of population health, because it means that changing the social determinants of health will have a beneficial impact on all SES groups, not merely those in poverty.

Social class differences in health

- Exist for almost every health outcome
- Exist as a gradient of risk
- Are strong and consistent findings
- Are not explained by traditional risk factors
- Are related to social distribution of wealth

Even if all of those at risk for disease could lower that risk, new people would continue to take their place, forever.

Leonard Syme, 2008

It is not simply that poor material circumstances are harmful to health; the social meaning of being poor, unemployed, socially excluded, or otherwise stigmatized also matters.

Richard Wilkinson and
Michael Marmot
WHO, 2003

15–17

Health impact attributed to race and social class: Racial disparities in life expectancy, excess deaths due to racial inequities, and differences in health linked to social class

At every step on the socioeconomic ladder, certain racial groups fare worse. African Americans, Native Americans, and Pacific Islanders tend to have poorer health outcomes than white Americans regardless of income, education, or even access to health care. In 1999, Congress requested an Institute of Medicine study to assess racial/ethnic health disparities. The resulting report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, found that racial and ethnic minorities receive a lower quality of health services, even when they have the same insurance status, income, age, and severity of conditions as their white counterparts. There was substantial evidence of racism, stereotyping, and lack of cultural sensitivity in the health care system that resulted in differential access to care, quality of care, and referral rates to specialty care. This bias in the health care system is just one of many ways that race and ethnicity continue to be strong social determinants of health outcomes.

There has been remarkable consistency in findings on social inequalities and health over time, and across cultures. Keep in mind a couple of things: There are different ways to measure social class, including education, income, occupation, and various combined measures. Indeed, this relationship appears to hold up regardless of the measure. The Gini coefficient, a measure of inequality in a society with 0 being perfect equality and 1 being perfect inequality, is frequently used by public health researchers and economists. The United States measures 0.4 according to this coefficient, which is the highest for western industrialized countries.

Race and socioeconomic status are often highly correlated and are sometimes used as proxy measures for each other. This can, however, obscure the independent ways that race and socioeconomic status influence health outcomes. Also, it is important to remember that, while race may seem more "fixed" than socioeconomic status, it is also a social construct with as many different possible measurements as social class. It may also be useful to directly measure factors associated with the experience of race, such as racism, discrimination, and disempowerment, to identify their

Racial disparities in life expectancy

In the US, white men live on average six years longer than African-American men (76 years vs. 70 years).

White men have not had a life expectancy of 70 years since the late 1970s.

Health United States, 2007

Excess deaths due to racial inequities

In the interval 1991–2000, 886,000 deaths could have been prevented by achieving equity between African Americans and whites.

In contrast, medical advances only averted 176,000 deaths during those years.

Woolf, et al, 2004

Differences in health linked to social class

- People in different social classes live different lives
- Occupational and household exposures
- Job demands
- Physical environments — neighborhoods
- Educational experiences
- Social Interactions and experiences
- Diet and other lifestyle factors

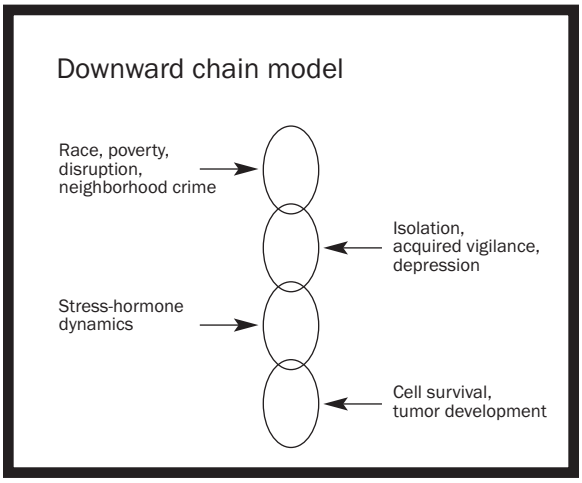
relationship with health outcomes. Camara Jones's framework for understanding the levels of racism can be useful when considering the various pathways between race and health. She argues that racism functions on three levels: *institutionalized*, such as differential access to health care; *personally mediated*, such as prejudice and discrimination among health care providers; and *internalized*, such as the acceptance by racial minorities of negative messages about their abilities and worth.

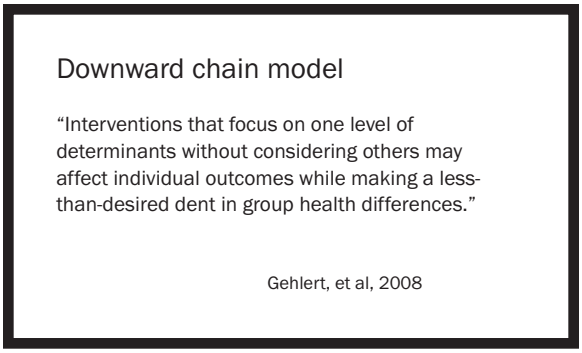
18–19

Explanation for the relationship between social class and health: The Downward Chain Model

There are competing explanations for the relationship between social class and health. Overall, such explanations might fall into the categories of material reasons, or psychological/social reasons. There is also a perspective that suggests that there is a reverse causality: People who are ill move down the social gradient because of their illnesses.

One way to portray this relationship is using what Gehlert and colleagues called the Downward Chain Model, with which they illustrated disparities in death rates due to early breast cancer among black women. Starting at the top of the "chain" in this model are the most macro social and environmental factors, for example the effects of race, poverty, and neighborhood or community dynamics. Working downward, these socioenvironmental factors then "link" to — or directly affect — the next level of causal element in the chain, psychological and behavioral factors leading to disease (e.g., depression and isolation). These psychological/behavioral factors, in turn, link to biological phenomena within the individual — for example, physiological stress responses and altered immune function — which subsequently lead to the last link in the chain, disease processes. A key feature of this model is the necessary interconnection between the layers of the disease dynamic. The authors caution that to try to address one "link" in the chain to the exclusion of the others — for example, considering behavioral factors in the absence of the socioenvironmental backdrops in which they occur — is to risk affecting disease processes in individuals while leaving unaddressed in the population critical disease-producing elements.



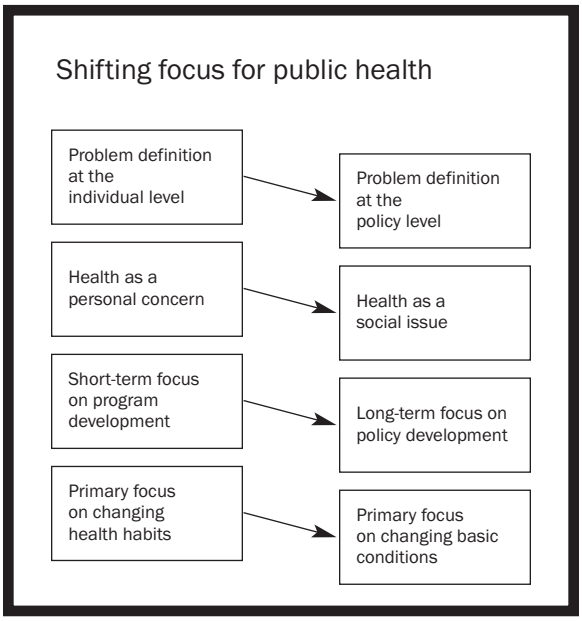


Up to a point, the health status of a society is a product of the overall level of income in that society. However, after reaching a basic level it becomes more important *how* the income is distributed, rather than the overall level. Hence, the highly unequal distribution of wealth in the US results in poor health indicators, despite the US having one of the highest per capita incomes in the world.

20 Moving ahead and shifting focus

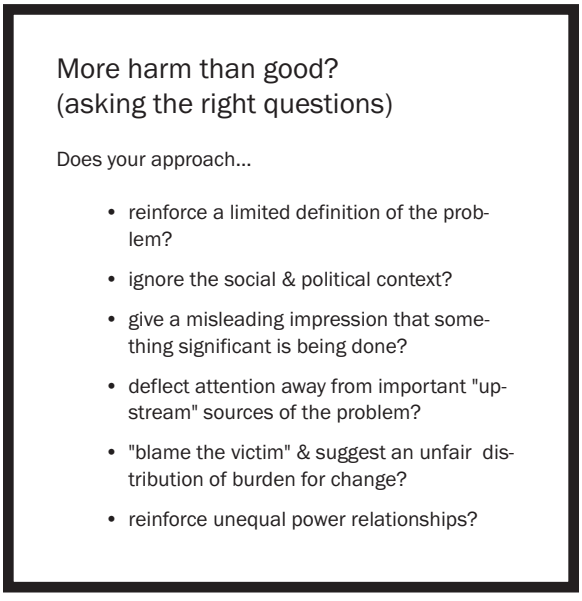
There has been remarkable activity over the past generation of public health research on the relationship between social inequality and health inequality. This remains a controversial and contentious issue because it is so politically charged. The answers will not only come from science, but also will emerge from a political discourse that confronts how we want to organize our society.

One of the main tasks of public health is to shift focus from the individual to the broader environment in which people live. In many cases this has significant political overtones, but in others it is simply a matter of following the science to a more pragmatic approach. The Haddon Matrix, which will be introduced in the next lesson, is a good example of a pragmatic approach rooted in data. However, as we shall see, even this approach has political ramifications when it comes up against issues like autonomy, free markets, and personal responsibility.



21 More harm than good?

We always need to ask ourselves whether our interventions actually make a positive difference. The answer to this is not always obvious. Indeed, it is useful to look back at the four ethical principles previously discussed when making such a judgment.



22 Public health advocacy

As we move ahead, keep in mind these essential elements of public health advocacy. In the end, public health is about blending science, community activism, social values, and politics to advance the interests of the public's health. This is always more complicated that it seems because the public health profession truly navigates along the nerve centers of our society. And, as mentioned previously, often raw nerves are hit, resulting in conflict, controversy, and very difficult struggles. Fluoridation, motorcycle helmets, needle exchange, reproductive rights, food and nutrition, guns, alcohol, tobacco, and automobile safety are just some of the issues that have touched such raw nerves.

Essential elements of public health advocacy

- Clear, specific policy goals
- Solid research & science base
- Values linked to fairness, equity, & social justice
- Broad-based support through coalitions
- Mass media used to set public agenda & frame issues
- Use of political & legislative process for change

discussion questions

A The US has the first or second highest per capita income in the world, and spends at least twice as much of its GDP on health care as any other nation. Yet, it tends to lag far behind other nations on basic health indicators such as infant mortality and life expectancy. What could explain this?

B Is an ounce of prevention really worth a pound of cure? What kinds of population-based approaches yield important outcomes?

C It may be understandable why poor people have worse health outcomes than the wealthy, but how do you explain the fact that even among those in the upper quadrant of income, where all people have their needs met, there is still a graded response? In other words, how do you explain that those less well off, overall, are less healthy? Is it more important for public health to focus on the whole population or the racial/ethnic subgroups that we know are most vulnerable?

D Advocacy has resulted in significant public health gains over the years. However, there seems to be relatively little emphasis on advocacy as a core public health approach. Why do you think there is resistance to more public health professionals being strong advocates?

skills-building exercise

After all…

The objective of this exercise is to help students become practiced at making the case that public health problems are due, in large part, to circumstances outside of any given individual's control. The exercise helps students connect the personal responsibility and market justice end of the spectrum to the institutional accountability, or social justice, end of the spectrum. To conduct this exercise, first ask the students to work individually to complete the statements listed below. Then, have students work in small groups in order to share and improve upon their responses. When the small groups have had adequate time to assess and revise each student's response, engage the class in a discussion about the experience they just had. Was it easy or difficult? What information do they need to make the case? Are some public health problems better suited to an upstream explanation than others? Why is it usually more difficult to make an environmental, as opposed to personal, argument?

Students should complete these (or similar) statements:

- Obesity rates have risen dramatically in the US population over the last 10 years. Of course, people can avoid obesity and improve their health and chances for living longer by eating healthy food and exercising regularly. Still, personal choices about diet and activity are not the only factor in the rise of obesity. After all…
- New treatments for childhood asthma are likely to improve health outcomes for children who suffer from the disease. It will be up to parents to be sure that children get the treatments they need. Yet, parents are not alone in bearing responsibility for preventing and treating childhood asthma. After all…
- Regular screenings for cervical, breast, and colon cancer can detect disease early enough for treatment, and often can prevent morbidity and mortality. Health care providers have a responsibility for informing their patients about the screenings they need, and patients need to seek treatment. However, to prevent cancer we, as a society, need to do more than that. After all…
- Tobacco is still the number one cause of preventable death in the US. Smoking cessation programs are an important mechanism to help reduce morbidity and mortality. But, there is much more that public health can do to reduce the death toll from tobacco. After all…
- Personal responsibility is essential when it comes to preventing HIV and other sexually transmitted diseases. Sexual partners must take initiative to protect themselves by using condoms, among other preventive practices. But there are other factors, in addition to personal responsibility at the time of a sexual encounter, that can prevent the transmission of HIV and other sexually transmitted diseases. After all…

assignments

1 Your state Public Health Director is in trouble again. In your last consultancy for her, you urged her to use a population approach as a basis for interventions. Now, community groups are arguing that there are lots of people at very high risk for disease who need screening and treatment programs. They say that it is a matter of social justice for the department to give people these needed services. You need to help the director decide whether or not an approach targeting a high-risk population might be better in this situation. Limit your advice to five pages.

2 There is a paradox in the practice of public health. Many public health professionals believe that health is largely determined by social influences that are external to the individual. However, they seem to spend much of their professional lives working on educational and service provision programs that are focused on personal and behavioral factors. In this context, their public health advocacy seems to focus on getting individuals to behave better, rather than getting society to be more fair and just. What do you think causes this paradox, and how might the profession overcome it?

possible guest speakers

- Public health department director, or other leaders of interventions
- State or local health officer
- Public health leaders of policy campaigns
- Community health advocates who work at the population level
- Legislators concerned with health disparities
- Epidemiologists studying the social determinants of health

required reading

Adler N, Boyce T, Chesney M, Folkman S and Syme L. Socioeconomic Inequalities in Health. *Journal of the American Medical Association,* 269(24): 3140-3145. 1993.

Guralnik J, and Leveille S. Annotation: Race, Ethnicity, and Health Outcomes — Unraveling the Mediating Role of Socioeconomic Status. *American Journal of Public Health,* 87(5): 728-729. 1997.

Kaplan G, Pamuk E, Lynch J, Cohen R, and Balfour, J. Inequality in income and mortality in the United States: Analysis of mortality and potential pathways. *British Medical Journal*, 312: 999-1003. 1996.

Kawachi I, Kennedy B, Lochner K, and Prothrow-Stith D. Social Capital, Income Inequality, and Mortality. *American Journal of Public Health*, 87(9): 1491-98. 1997.

Kliegman R. Neonatal Technology, Perinatal Survival, Social Consequences, and the Perinatal Paradox. *American Journal of Public Health*, 85(7): 909-913. 1995.

McKeown T. Determinants of Health. *Human Nature*, 1(4):60-67. 1978.

Rose G. Sick Individuals and Sick Populations. *International Journal of Epidemiology*, 14(1):32-8. 1985.

World Health Organization Social Determinants of Health report
http://www.who.dk/document/e81384.pdf

suggested reading

Dahlberg LL, Krug EG. Violence — a global public health problem. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. *World Report on Violence and Health. Geneva, Switzerland: World Health Organization; 2002*:1-56. Available at http://www.cdc.gov/ncipc/dvp/Social-Ecological-Model_DVP.htm

Doll, R. Health and the environment in the 1990s. *American Journal of Public Health*, 82(7): 933-941. 1992.

Evans RG, Barer ML, and Marmor TR. *Why Are Some People Healthy and Others Not?* Aldine De Gruyter: New York. 1994.

Gebbie K, Rosenstock L, and Hernandez LM. *Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21st Century*. The National Academies Press: Washington, DC. 2003.

Gehlert, S, Sohmer D, Sacks T, Mininger C, McClintock M, and Olopade O. Targeting health disparities: A model linking upstream determinants to downstream interventions. *Health Affairs*, 27(2): 339-349. 2008.

Jones C. Levels of Racism: A Theoretic Framework and a Gardener's Tale. *American Journal of Public Health*, 90(8);1212-15. 2000.

Kawachi I, Kennedy BP, and Wilkinson RG. *The Society and Population Health Reader: Income Inequality and Health*. The New Press: New York. 1999.

Marmot, MG. Creating healthier societies. *Bulletin of the World Health Organization*, 82(5): 320-321. 2004.

Marmot M, and Wilkinson RG (Eds.). *Social Determinants of Health*. 2nd Edition. Oxford University Press: London. 2006.

Polednak AP. *Segregation, Poverty, and Mortality in Urban African Americans*. Oxford University Press: New York. 1997.

Raphael D. Health inequities in the United States: prospects and solutions. *Journal of Public Health Policy*. 21(4): 394-427. 2000

Rose G. *The Strategy of Preventive Medicine*. Oxford University Press: New York. 1992.

Syme, SL. Reducing racial and social class inequalities in health: The need for a new approach. *Health Affairs*, 27(2): 456-459. 2008.

Wilkinson RG. *Unhealthy Societies: The Afflictions of Inequality*, Routledge: London. 1996.

other resources

Institute of Medicine report. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, 2002. http://www.iom.edu/File.aspx?ID=14973.

Institute of Medicine report. *Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21st Century.* 2003. http://www.iom.edu/?id=16743

National Center for Health Statistics. *Health, United States, 2007 With Chartbook on Trends in the Health of Americans*. Hyattsville, Maryland: 2007.
http://www.cdc.gov/nchs/hus.htm

Public Health Agency of Canada. *The Population Health Template: Key Elements and Actions that Define a Population Health Approach*. 2001. http://www.phac-aspc.gc.ca/phsp/news2001-bulletin2001/tool.php

Unnatural Causes: Is inequality making us sick? A seven part documentary series exploring racial and socioeconomic inequalities in health from California Newsreel. See Web site to view episodes and download toolkit and discussion guide.
http://www.unnaturalcauses.org/

3

Rationale for Advocacy and a Framework for Action

introduction

Advocacy plays a central role in translating research into public policies that can advance the well-being of communities. Public health faculty members sometimes caution their students not to be advocates because researchers, if perceived as biased, can lose their credibility. In certain circumstances, it makes little difference whether the lack of objectivity is an actual bias or simply perceived. Either way, the validity of the research is called into question. Organizations and persons generally hostile to public health concepts recognize this, and sometimes actively attempt to smear the reputation of a researcher so as to render him or her less effective in the policy space. Thus, admonishments not to be an advocate may make sense in certain spheres of public health, where one might anticipate such treatment.

At the same time, public health needs people who can take research findings and use them to inform policymakers and influence the development and implementation of policy. We believe that it will be to the benefit of the public to have this function filled, at least in part, by persons, including researchers, trained in public health.

This lesson includes discussion of:

- How research can inform upstream actions;
- Tensions inherent in research and advocacy; and
- A useful framework for addressing public health problems.

The purpose of this lesson is to help students to be well grounded in public health research and help them understand and appreciate the link between data and action.

learning objectives

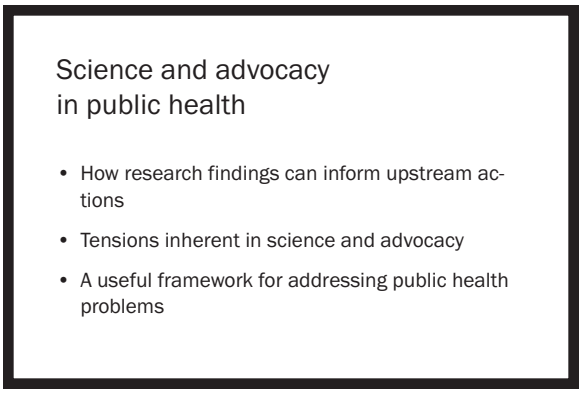
By the end of this lesson and completion of all assignments, students will be able to:

1. Describe the difference and interface between public health research and public health advocacy
2. Determine
   a. The health status of a specific segment of the population (e.g., disparities by gender, ethnicity, nativity)
   b. Population groups at highest risk of a specific disease, injury, or disability
   c. How to put that information into a larger (e.g., social, economic, historical, global) context
3. Marshal information to generate action options
4. Identify multiple intervention strategies and intervention points for public health advocacy

key points to be made in lesson

1 Research and advocacy in public health

This lesson will focus on these three key points (read list from slide). We will start at a place that is probably familiar to most students: public health data and how it can be used to inform social change efforts. We will move on to discuss the tensions between these two and end with a framework that helps organize thinking and efforts to improve the health of the public.

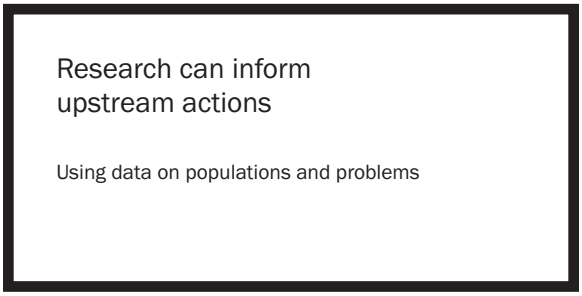


2 Research can inform upstream actions

Some public health students are not very interested in research design, statistics, or, for that matter, research findings. These students sometimes emphasize that it is more important to "work with the community." Focusing on the community to the exclusion of research can result in people not realizing or ignoring certain public health problems. Community engagement can be a necessary component of good public health practice, but can also be well-informed by research.

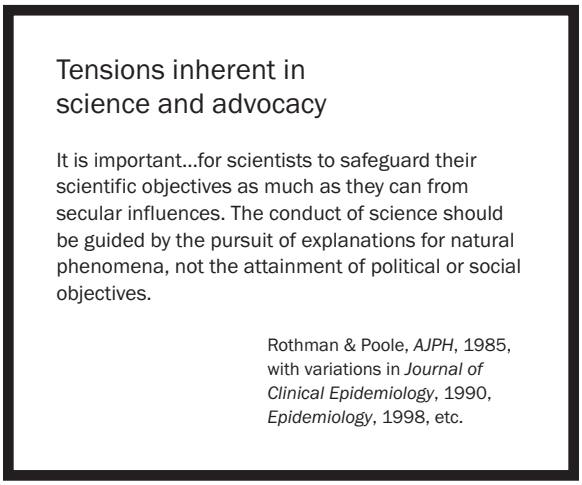
Some people also might make the common mistake of thinking that working with some individuals who reside in a particular geographic locale or who have a specific problem or who have certain demographic characteristics, is working with "the community." Whereas it is reasonable to work with specific groups and in specific locales, public health takes a step back to look at the whole, the entire population.

At times, public health work is a bit like the old adage of not seeing the forest for the trees. Focusing our studies on how individual risk factors affect health is another way we can become distracted from the larger context. Comprehensive public health prevention work always has the forest in mind. Take a look at what we know about populations and health problems, as reflected in US mortality data. *[Instructor: see In-class Skills-building Exercise #1.]*



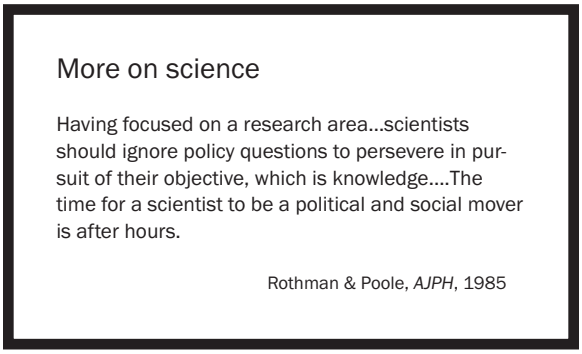
3 Tensions inherent in research and advocacy

This slide quotes outstanding epidemiologists who conduct careful studies and have authored textbooks that are used in many epidemiology courses across the nation. As you can see, they have a very strong stance that research is science and that it should be and remain "pure." That is, research should be limited to conclusions from the study itself, uncontaminated by considerations about the implications of the findings for policy and practice.



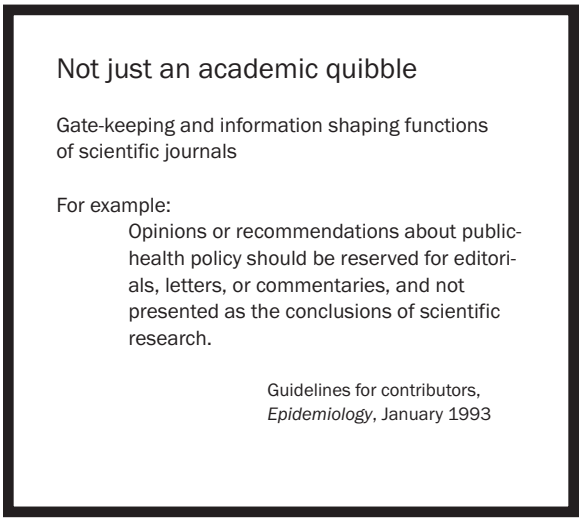
4 More on science

In this next quote, the same authors assert that a scientist/researcher should not be a "political and social mover" in the context of his or her work. Rather, such activities should be reserved for one's personal life, one's "after hours" life. This is the message that many public health students have received in the past and continue to receive in their university education.



5 Not just an academic quibble

How does the perspective that scientists should keep themselves separate from political and social forces play out? One example is that of scientific journals, and in particular, how editors serve as gate-keepers, shaping what information is published. Indeed, journals typically have guidelines for those who are interested in publishing in their pages. Consider this statement from the guidelines to authors wanting to submit their work to *Epidemiology,* one of the mainstay public health journals. The message is that the policy implications of research findings do not belong in a scientific article, but rather are the stuff of opinion pieces. A quick check of the journal's online instructions to authors in May 2008 maintains this general stance: "We discourage policy recommendations in research papers; such recommendations are reserved for commentaries."

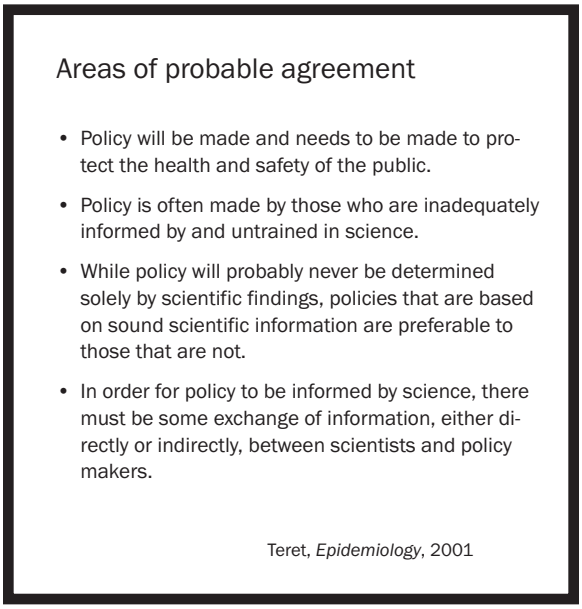


6 What are the implications of a research-only focus?

So what are the implications of a research-only focus in public health? *[Instructor: see In-class Exercise #2.]*

7 Areas of probable agreement

Steve Teret, an attorney trained in public health and Professor at Johns Hopkins School of Public Health, made some important points in a round of discussions regarding the role of policy in leading public health journals. His points probably are those with which most public health people agree. The question left both unsaid and unanswered here, though, is how *do* and how *should* public health practitioners bring research to bear on policy?



8 From science to action

Carl Sagan, in his book *The Demon-Haunted World: Science as a Candle in the Dark*, makes a compelling case that societies have advanced because of science and that science is a necessary component of social advancement. Consider the example of an earthquake: People used to think that earthquakes, volcanoes, and other such events were signs that a god was angry. Virgin girls and livestock were sacrificed in an attempt to appease the god or gods. And, sure enough, if enough girls and animals were killed, the shaking did stop. With systematic observation over time, however, earthquakes and volcanoes came to be seen as "natural" phenomena, and girls and animals were no longer sacrificed in response. In another example, the miasma theory, which originated in the Middle Ages, held that diseases were caused by toxic vapors. Miasma theory was used to explain why cholera epidemics occurred in places where water smelled foul, and the theory was erroneously supported when improvements in sanitation systems reduced the number of cholera cases. Although miasma theory made the connection between dirtiness and disease, it was not scientifically founded. The point here is simply that having an opinion or a belief system is not enough. Science and scientific findings have an important role to play and must be brought to the table in public health efforts.

Some researchers consider science or their own research findings to be so strong that they think that "the data speak for themselves." However, someone must always interpret the data and make the data both available and accessible. Recently, these efforts have not been left solely to scientists and researchers; many public health practitioners work to "translate" research findings from the language of scientific journals to the language of decision makers and members of the general public.

One question that emerges from all this is, "How much research is enough?" The answer to that question varies by the topic under study as well as the place that topic has in society. For some topics we are comfortable moving forward with suggestive evidence, but for others we demand a higher level of "proof" before taking action. One attempt to address this dilemma is the Precautionary Principle.

From science to action

- Without a science base, public health advocacy risks being just another dueling ideology
- Data don't speak for themselves
- But how much and what kind of research is sufficient?

9 Precautionary Principle

The Precautionary Principle is a concept with roots in Europe's environmental movement in the 1970s. The definition shown here — based on an important convocation in 1998 of treaty negotiators, activists, scholars, and scientists from the US, Canada, and Europe — can offer a useful guide for public health. The Precautionary Principle has been defined in various ways, with a common core being that we are not going to know all we might want to know before we are required to take action. Global warming is an excellent example of such a problem. After several decades of debate, including the voices of nay-sayers and those who overstated the available data, the scientific community largely has come to agreement that global warming is real and a danger to the existence of humans and other life on Earth. Some opinion leaders and powerful policy-makers, however, challenge this conclusion, asserting that there is insufficient evidence for global warming. Their stance is not inconsequential; they block emissions standards and other regulations and policies that might slow global warming. The failure of scientists to communicate their case for global warming, the efforts of businesses that have an interest in remaining unregulated, and some politicians' general aversion to views other than their own, have all combined to result in, among other things, the United States not signing the Kyoto agreement nor other major efforts to limit the effects of global warming.

> **Precautionary principle**
>
> When an activity raises threats of harm to human health or the environment, precautionary measures should be taken even if some cause and effect relationships are not fully established scientifically.
>
> Wingspread Conference, Racine, WI, 1998

There often will be disagreements about what constitutes sufficient evidence or even what constitutes useful data. Some researchers have questioned the usefulness of collecting vast amounts of surveillance data, such as information on new cases of sexually transmitted infections. Although we need to monitor disease incidence to guide our interventions, epidemiologist Charlotte Kent warns that we must not simply collect data for data's sake. She points out that there is a great deal of unused and underutilized data that public health has spent a tremendous effort collecting. There are many other examples of conflicting values and interests in public health that will be addressed more fully later in this course.

10 Various perspectives

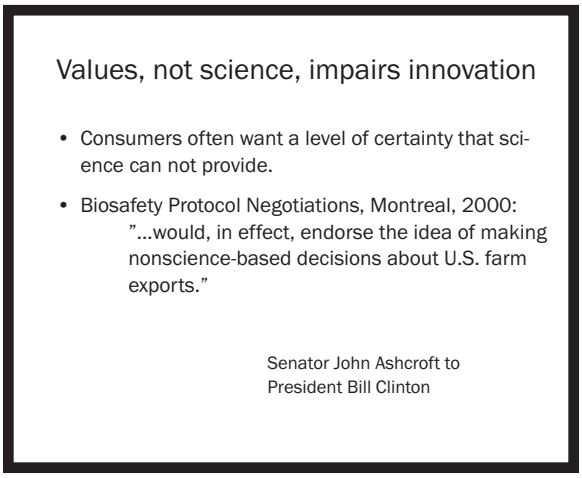
Science will not always have all the answers that everyone wants when action must be taken, but that is not reason enough to exclude research from policy and regulation. Research must have a seat at each decision-making table. Moreover, leaders within the scientific community have spoken about the importance of researchers fulfilling a social contract, of sorts, when they receive government funding to focus on applied research to improve the lot of society.

> **Various perspectives**
>
> "Urgent and unprecedented environmental and social changes challenge scientists to define a new social contract...a commitment on the part of all scientists to devote their energies and talents to the most pressing problems of the day, in proportion to their importance, in exchange for public funding."
>
> J. Lubchenko, 1997 AAAS Presidential address

11 Values, not research, impair innovation

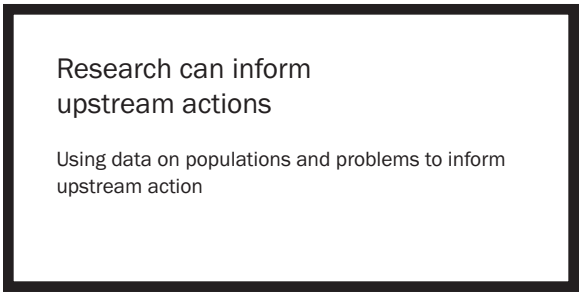
People often want information that science does not have, or they want a level of certainty that can not be provided. For example, people want to know: can I be guaranteed that I will not have a bad side effect if I take a specific medication? No, there is no such guarantee. Research can, however, quantify the level of risk, and then drug companies, government agencies, and the general public can decide if the nature and frequency of the risk is acceptable.

Bioengineered foods remain a source of controversy across and within nations. The second part of this slide is a quote from a letter written by Senator John Ashcroft to President Bill Clinton, asserting that the US would not want to make decisions that are not based on research. The irony of this letter is that Ashcroft, after losing his bid to be re-elected to the Senate, was appointed Attorney General by the next President, George W. Bush, whose administration was marked by a general mistrust of, and disregard for, research and the scientific process. Competing and shifting priorities affect how research is, or is not, taken into account in policy making.



12 Research can inform upstream actions

How, then, can research inform upstream actions? Let's return to the NCHS mortality data and try another in-class exercise to illustrate how this could occur. *[Instructor: see In-class Exercise #2].*



13 Tools for change

[Instructor: Connect this exercise to the upstream action ideas generated in the in-class exercise. If students used all four tools, the concepts should be relatively easy to grasp. If some of the tools were not mentioned by the students, spend some extra time to be sure that students understand the content.]

We now turn from the specific populations and health problems in the in-class exercise to draw attention to four tools for change:

Education is a common response to health problems, particularly in the US, where individual autonomy is prized. This approach assumes that if people know about risks, they will take appropriate action to reduce them. This sometimes happens, but often not. For example, although it is common knowledge that smoking contributes to the risk of heart disease and cancer, a substantial portion of the population still smokes.

Tools for change

- Education
- Regulation
- Legislation
- Litigation

Regulation consists of the guidelines or rules by which companies and organizations create their products and run their operations. A good example of a change in business practices that can be considered a voluntary regulation is the decision to change the US food supply to include folic acid in bread. Folic acid prevents certain birth defects if taken in the very early stages of pregnancy. Putting folic acid in bread virtually assures that every woman will get this supplement in the first weeks of their pregnancies.

Legislation involves lengthy and complicated processes, but it can be an extremely effective tool for effecting population-wide change. Examples include efforts in New York and elsewhere to eliminate the use of partially hydrogenated oils (i.e., transfats) in all restaurants in the state and California's ban on junk foods in public schools.

Litigation is a tool that can be used at various points, albeit perhaps most often when other avenues have been exhausted. An example of the use of litigation to protect health is when the McDonald's fast food chain was sued because a woman sustained third-degree burns on her inner thighs, buttocks, perineum, and genital and groin areas, after the coffee cup she placed between her legs spilled as she attempted to remove the plastic lid to add cream and sugar. Some might argue that education was needed. Although carry-out coffee cups often carry a printed warning along the lines of "Caution: Contents are hot," perhaps an educational campaign would change consumers' semi-frequent behavior of putting a coffee cup between their legs as they pull away from a drive-through window. Or perhaps regulation is needed. McDonald's could set standards for their products that would take health and safety into account. Consumers want their coffee to be hot, but it need not be served at a temperature that can destroy nerve endings in the skin. Or, maybe this is an example of a "frivolous law suit." *[Instructor: Ask students to discuss the question. Refer to information provided on the website listed under Other Resources for greater details of this case. In brief: At the time of the injury, McDonald's actively enforced a policy of serving coffee between 180 and 190 degrees Fahrenheit. This was substantially higher than the temperature used by other establishments. For reference, coffee made at home is usually 135 to 140 degrees Fahrenheit. Burn hazards exist with liquids hotter than 140 degrees. In the ten years before this incident, McDonald's had received more than 700 claims by people who had been burned by their coffee, some of whom had incurred third-degree burns.]*

Now, turn to the use of these tools in a framework for addressing public health problems.

14 A framework for addressing public health problems

We are all familiar with the public health triad of host, agent, and environment. The matrix I am going to talk about now was developed in the early 1970s by William Haddon, a physician who earned his MPH at the Harvard School of Public Health and went on to create and lead the National Highway Traffic Safety Administration. The matrix, which describes prevention of injuries from motor vehicle crashes, has two central dimensions: time and focus/target of the intervention. While Haddon developed this for injury control, we'll see that it can be used for analyzing and generating ideas for moving upstream on other public health problems.

A framework for addressing public health problems

Haddon Matrix

Originally designed (1972) for injury prevention, specifically motor vehicle crashes

- Two central dimensions
- Time
- Focus/target of the intervention

15 Haddon Matrix

As you can see, the three rows show three time periods relative to an event that has — again, continuing with Haddon's original example of a motor vehicle crash — the potential of producing an injury. These periods include before the event, during the event, and after the event. This time span can be thought of as roughly corresponding to primary, secondary, and tertiary prevention. The four columns each identify a point of intervention: the host (the human); the vehicle (literally, the motor vehicle in this example); and two columns for the environment, the first being the social environment, and the second being the physical environment. Consider Haddon's matrix with the prevention of motor vehicle injuries as the goal.

Haddon injury matrix
(Haddon, 1972)

			environment	
	host	**vehicle**	**social**	**physical**
pre-event				
event				
post-event				

16 Haddon Matrix – primary prevention

Focusing first on the pre-event phase, we can identify several activities that apply to the entire population at risk. For the host, consider the example of driver's education; for the vehicle, design and equipment such as horns; for the social environment, designating a driving age; and for the physical environment, good highway design. Each of these examples has the potential of reducing crashes and injuries by preventing crashes from occurring in the first place. For example, if drivers are trained how to drive they may be less likely to engage in risky behaviors. And, if highways are designed well (e.g., with an appropriate number of lanes, appropriately timed stop lights, and curves that are not too sharp), drivers may be required to navigate fewer hazards.

Haddon injury matrix: pre-event

			environment	
	host	**vehicle**	**social**	**physical**
pre-event	driver's education	design, equipment	driving age	road design
event				
post-event				

17 Haddon Matrix – secondary prevention

Moving to the event phase, consider examples of motorcycle helmets that protect the contents of the cranial cavity when a crash occurs; vehicle restraint systems (i.e., air bags that automatically inflate when a collision occurs, or lap and shoulder belts that restrain passengers when a vehicle's brakes are applied); the enforcement of passenger restraint laws (e.g., that drivers and passengers must be belted, and infants and children must be in age-appropriate safety seats); and the placement of concrete barriers between lanes of oncoming traffic so that, if there is a crash on one side of the roadway, it does not cross over into on-coming traffic. None of these event-approaches will prevent a crash, but each has the potential of preventing injury or death, should a crash occur.

Haddon injury matrix: event

			environment	
	host	**vehicle**	**social**	**physical**
pre-event				
event	motorcycle helmets	restraint systems	enforce laws	concrete barriers
post-event				

18 Haddon Matrix – tertiary prevention

The post-event phase may be the easiest to identify examples for because it is the phase on which we, as a society, typically focus. This is the equivalent to focusing downstream. Providing medical care and rehabilitation services for people who have been injured is an example for addressing the "host" in this phase. Repairing vehicles that have been damaged in crashes is an example that would fit in the "vehicle" box. Laws that mandate enhanced sentencing when alcohol is involved is an example of an after-the-fact socio-environmental action, as are laws that require hospital emergency departments to provide care to critically injured persons regardless of their ability to pay or legal residency status. Repairing the traffic signs, guard rails, etc. that are damaged in motor vehicle crashes is an example of a post-event action related to the physical environment.

Haddon injury matrix: post-event

			environment	
	host	**vehicle**	**social**	**physical**
pre-event				
event				
post-event	medical care	repair vehicles	medical services	fix road signs, etc.

19 Haddon Matrix – complete

Consider the examples we have generated. What do we know about the effectiveness of these ideas? Have they been evaluated?

[Instructor: Return to each box and consider the efficacy of each intervention. During this discussion, continue to generate alternatives, particularly those with limited evaluation or with which society is currently grappling.]

Haddon injury matrix: completed

			environment	
	host	**vehicle**	**social**	**physical**
pre-event	driver's education	design, equipment	driving age	road design
event	motorcycle helmets	restraint systems	enforce laws	concrete barriers
post-event	medical care	repair vehicles	medical services	fix road signs, etc.

For example, research shows that *driver education* generally has been shown not to reduce crashes or injuries among young drivers, the population that most intensively receives this intervention. Two outcomes of these evaluations are that school-based drivers education programs — those that have been supported by public dollars — are no longer common, and that public health has sought other ways to reduce the high motor vehicle crash rates among young drivers. One such newer approach is *graduated driver's licenses,* developed by Patricia Waller, a long-time public health motor vehicle safety expert. In this approach, young drivers receive limited driving privileges and, if there are no violations, the privileges increase over time. Another example is that of *automated collision notification systems,* which are standard in some recently manufactured vehicles. Do these systems reduce debilitating injuries by getting EMS to the scene faster? (As of this writing, there are, to our knowledge, no evaluations of

these systems.) And what about *mobile phone use* and the research that shows that dialing is not the high-risk activity, but rather talking on the mobile phone increases risk of a crash. What might be a public health intervention to reduce crashes and injuries associated with cell phone use? What about a ban on the use of mobile phones in vehicles? Who would likely support a ban? Who would oppose it? Later in this course, we will identify issue stakeholders and ways with which to form effective coalitions in order to effect change on issues such as these.

20 Haddon Matrix – another example

[Instructor: Practice thinking about primary, secondary, and tertiary interventions. Using an overhead transparency with a blank Haddon matrix on it, use one student group's in-class exercise #2 as a starting point. Solicit additional ideas from the students in the class.]

Haddon injury matrix: another example

	host	vehicle	environment: social	environment: physical
pre-event				
event				
post-event				

Other examples of issues on which to practice might include prevention of health problems related to:

cigarette use (e.g., educational campaigns about the increased risk of cancer and heart disease among smokers; legislation that substantially increases the tax on each pack of cigarettes that is sold; regulations that require cigarettes to be self-extinguishing, so as to reduce injuries from house fires; changing physical layouts of stores such that potential purchasers must ask for, rather than have direct physical access to, the product)

sexually transmitted diseases (e.g., school-based programs to educate boys about STDs; placing a bowl of free condoms at locations where sexual activity is more likely to occur, such as bath houses; mandating an immunization that prevents HPV; social norms campaigns to promote monogamy). *[Instructor: see the 2003 Huppert and Adams Hillard article listed in the suggested readings for more.]*

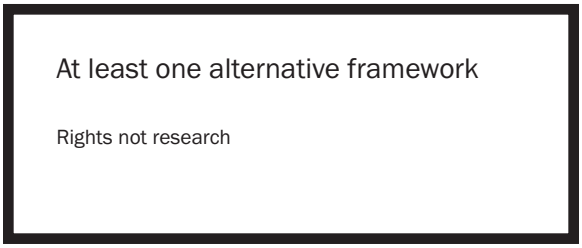
[Instructor: after completing the matrix, return to each box and ask students what is known about the efficacy of each intervention. If a more effective intervention is available, replace the original content with the new approach.]

21 Moving beyond research to action

Now that we have identified what could be done that might work, how would we go about making any one of those things happen? Most public health workers, whether or not they expected to be, are involved in some form of advocacy. Some will advocate for their particular programs or agency units in order to ensure that resources are allocated to future work. Others will advocate within the community to be sure that a particular health problem or population group is included in existing efforts. And some will be involved in advocacy of the sort that has the potential of bringing about broader change, which, in this course, we are calling social change. Competing priorities, loyalties, and value systems will lead to the development of multiple agendas. It is the task of public health advocates who want to effect systemic change to bring research to the table, and keep the focus upstream.

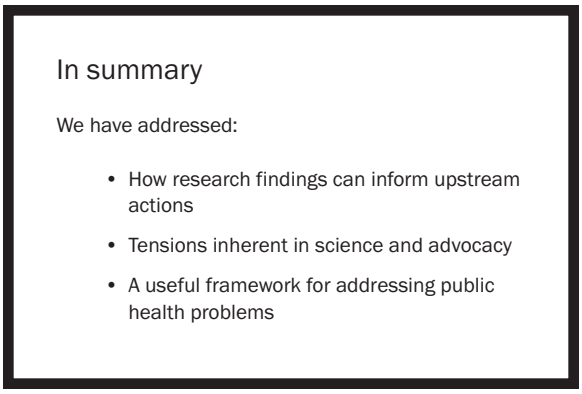
22 At least one alternative framework

There is at least one additional framework that can be brought to bear and that is a focus on *rights* rather than research findings. In some nations, health care is considered a basic right, and yet that is not the case in the US where, at least theoretically, research is used to make decisions about the allocation of health care resources. The two perspectives are not necessarily incompatible; human rights approaches often use research to document problems and progress (e.g. gender disparities in infanticide in developing countries). But, the basic premises differ. The scientific approach is about facts; what questions are asked and what data are collected will vary depending upon the nature of the research undertaken. For example, research addressing social equity might collect data and be used to create policies that would minimize health disparities between the rich and poor. Meanwhile, a neoclassical economic approach might collect data and be used to develop policies that maximize average longevity or provide the best health outcome per dollar. By contrast, there is no empirical question associated with human rights — it is about values, not facts. A human rights framework seems to be more common in international and global health work than in public health work within the US.



23 In summary

In this lesson, we have discussed how research can inform upstream actions, explored tensions between research and advocacy, and generated ideas for prevention work using a matrix approach.



discussion questions

A Are there areas (e.g., either populations or topics) in which public health should adopt a research-only approach? If yes, what are they? Why should a research-only approach be taken? Are there circumstances in which a research-only approach for this population/topic should, or could, be changed? What are those circumstances?

B Aside from trying to directly influence a piece of legislation, a questionable action in certain work settings (e.g., public universities), how can a researcher get his or her research into the policy space?

skills-building exercise

The goals of these exercises are to increase students' abilities to:

- Grasp the "big picture"
- Work with others under time pressure
- Concisely convey information

Make and distribute copies of the most recent NCHS mortality data tables. Divide the class into groups of 4-6 students and assign different topics (e.g., health of Hispanics, diabetes, health of 18-24 year olds).

In-class exercise #1:

Ask each group to review the data and then to describe, in two minutes, the population mortality patterns to the class. Allow 15 minutes for the data review, and two minutes for each group to report to the class.

In-class exercise #2:

Ask each group to generate, based on the data they reviewed and their understanding of the basis of the health problems, a list of potential upstream actions with which to reduce mortality. Allow 15 minutes for the generation of ideas, and two minutes for each group to report to the class.

In-class exercise #3:

Solicit opinions from the students about implications of social advocacy for:

Researchers (e.g., in many universities, greater value is given to faculty, and to the work of those faculty, who do not actively seek and identify connections between research and application; as such, researchers may avoid drawing important associations for fear of being perceived as "soft," or "not scientific enough")

Advocates (e.g., may perceive research and researchers to be irrelevant to their work, thus, missing out on important information that could inform and improve their efforts)

Policy (e.g., policy-makers must review a large scientific literature and infer implications for policies under consideration. That process takes considerable time and expertise, meaning it likely will not happen. Thus, policy will be made with less input from research studies)

Public health (e.g., students may be trained by faculty who have been encouraged to consider the application of their research to be beside the point; as such, public health steps away from its applied, social justice mission)

assignments

1 Identify a pending legislative bill, using your state's online legislative tracking system, which pertains to a public health topic of interest to you. Review the draft of the bill. Write a two-page paper about research and the bill. Consider: Were data used to inform the rationale/intent for the bill? (If so, were the data presented in a clear and even-handed manner?) What (other) data could have been brought to bear on the topic? Might the absence of these latter data be damaging to the likely success of the bill or the health of the public? What are some of the arguments that might arise against the bill? Include a print-out of the bill when submitting this assignment.

2 Identify an advocacy organization online. Write a two-page paper addressing the following questions; be sure to list the link to the organization in your paper: Do these advocates cite research when describing their purpose or goals? What might have been the basis for citing (or not citing) research? What effect do you think citing (or not citing) research has on those visiting the organization's website, or the organization itself?

possible guest speakers

- Public health agency head (i.e., government, nonprofit) to speak about the relative roles of research and advocacy, on a recent success on a topic of public health concern (e.g., nutrition, smoking, firearms)
- Researcher whose work has been caught in political crossfire
- Researcher who disseminates study findings beyond traditional academic outlets
- Advocate who uses research well when communicating with community groups, policy-makers, the media, etc.

required reading

Chapman S. Advocacy in Public Health: Roles and Challenges. *International Journal of Epidemiology*, 30: 1226-32. 2001.

Gamble VN, Stone D. US Policy on Health Inequities: The Interplay of Politics and Research. *Journal of Health Politics, Policy and Law*, 31:93-126. 2006.

Runyan CW. Using the Haddon Matrix: Introducing the Third Dimension. *Injury Prevention*, 4: 302-307. 1998.

Shultz J. Research and Analysis: Advocacy by Fact, Not Fiction (pp. 83-95). *The Democracy Owners' Manual, A Practical Guide to Changing the World*. Rutgers University Press: New Brunswick, NJ. 2002.

Tallacchini M. Before and Beyond the Precautionary Principle: Epistemology of Uncertainty in Science and Law. *Toxicology and Applied Pharmacology*, 207(2 Suppl): 645-51. 2005.

suggested reading

Appell D. Ashcroft letter to Clinton. The New Uncertainty Principle: *Scientific American*, 2001; 284:18-19.

Haddon W. A logical framework for categorizing highway safety phenomena and activity *Journal of Trauma*: 1972;12:193-207.

Huppert JS, Adams Hillard PJ. Sexually Transmitted Disease Screening in Teens. *Current Women's Health Reports*, 3:451-8. 2003.

Kent C. STD surveillance: Critical and costly, but do we know if it works? *Sexually Transmitted Diseases*, 24(2);81-2. 2007.

Lewin NL, Vernick JS, Beilenson PL, Mair JS, Lindamood MM, Teret SP, Webster DW. The Baltimore Youth Ammunition Initiative: A Model Application of Local Public Health Authority in Preventing Gun Violence. *American Journal of Public Health*, 95:762-5. 2005.

Lubchenko, J. Entering the Century of the Environment: A New Social Contract for Science. *Science*, 1997 AAAS presidential address 1998; 297:491-497.

Lytton TD. Using Litigation to Make Public Health Policy: Theoretical and Empirical Challenges in Assessing Product Liability, Tobacco, and Gun Litigation. *Journal of Law, Medicine and Ethics*, Winter:556-564. 2004.

McKinlay JB, Marceau LD. To Boldly Go… *American Journal of Public Health*, 90(1):25-33. 2000.

Michaels D, Monforton C. Manufacturing Uncertainty: Contested Science and the Protection of the Public's Health and Environment. *American Journal of Public Health*, 95:S39-S48. 2005

Rabito F, White L, Shorter C. From Research to Policy: Targeting the Primary Prevention of Childhood Lead Poisoning. *Public Health Reports*, 119:271-278. 2004.

Rothman KJ, Poole C. Science and Policy Making. *American Journal of Public Health*, 75(4):340-1. 1985.

Runyan CW. Back to the Future: Revisiting Haddon's Conceptualization of Injury Epidemiology and Prevention. *Epidemiology*, 25:60-64. 2003.

Sagan C. *The Demon-Haunted World: Science as a Candle in the Dark*. Random House: New York. 1995.

Simpson HM. The evolution and effectiveness of graduated licensing. *Journal of Safety Research*, 2003;34:25-34.

Teret SP. Policy and Science: Should Epidemiologists Comment on the Policy Implications of Their Research? *Epidemiology*, 12:374-5. 2001.

Teret SP, Michaelis AP. Litigating for Native American Health: The Liability of Alcoholic Beverage Makers and Distributors. *Journal of Public Health Policy*, 26:246-59. 2005.

Tesh S. Miasma and "Social Factors" in Disease Causality: Lessons from the Nineteenth Century. *Journal of Health Politics, Policy and Law*, 20(4):1001-24. 1995.

other resources

Wingspread Statement on the Precautionary Principle:
http://www.sehn.org/wing.html

McDonald's Scalding Coffee Case:
http://www.lectlaw.com/files/cur78.htm

4

Policy Analysis

introduction

Policy can be understood as the formal rules that govern social ordering. In the public arena, policy is made through legislation, agency rules and decisions, and the judicial process. At the same time, much policy is made privately, by families, businesses, or community institutions such as schools or neighborhood associations. "No chewing gum in class" is a privately-created policy that nearly all of us can remember. The Supreme Court's landmark 1954 decision in *Brown v Board of Education*, which replaced the nation's formal public policy of racial segregation and inequality with one favoring integration and equality, is an example of public policy-making. Similarly, Congressional passage of the Clean Air Act in 1972 is also an example of public policy-making.

The most common result of public policy-making is law: legislation, regulations, agency decisions, and judicial rulings. In the private sector, privately observed rules of conduct are standard outcomes of the policy-making process. Policies can be written or unwritten, complex or simple; based on extensive scientific evidence and fact-finding, or a reflection of the values of those in charge and with the political clout to get their way. Whatever their form or their scientific or evidentiary base, policies are constantly in flux, moving in reaction to the shifting social, economic, and political environments in which they operate. In other words, as society changes, so do its rules of conduct as embodied in policies.

Some policy shifts, such as the end of legally sanctioned racial segregation, offer an extraordinary example of fundamental policy changes that capture a moment in the evolution of society as a whole. Other policy changes are more modest, affecting particular communities or groups; indeed, relatively small changes are the policy norm. But whether a policy signals a major social revolution, or a revisiting of the norms within a single community (think of a city council vote in a small community to create a new playground), policy and the policy-making process represent the continuing realignment of a wide array of social, political, and economic interests, as well as the ability of policy stakeholders with shared values and aims to translate their alignment into the adoption of new policy.

This lesson explores public policies, both large and small, that relate to the public's health. It also examines the policy-making process with which change is produced. Experts in policy-making, such as John Kingdon, characterize a policy breakthrough as "an idea whose time has come." How and why policy breakthroughs occur is what great policy-makers and policy advocates learn, through study, practice, instinct, or a combination of the three.

Public policy-making is a challenge in any society, but is particularly so in the US. It is not simply that there exists a rich array of competing and powerful social and political interests. In framing the Constitution, the nation's founders went out of their way to devise a system of governance whose powers are diffuse, decentralized, and highly interstitial; a reflection, in other words, of a society that emphasizes and values individualism and the great level of freedom of individual liberty and property ownership. This diffuse and decentralized approach to public governance carries over to state governments as well. As at the federal level, state governance — as with the governance of localities — is shared among multiple branches of government that often share overlapping powers.

The process of policy-making is also an intensely political one, as strong and competing interests attempt not only to control how a problem will be solved, but also to actually define the nature and scope of policy problems themselves. This is because the definition of the problem so decisively influences the types of solutions that policy-makers will consider. Scholars of the policy-making process, such as John Kingdon and Deborah Stone, underscore the intensely political nature of policy-making. In a similar vein, students of the role of courts in shaping policy point to the ways in which politics influence not only who

gets selected to be a judge, but the actual nature of the decisions themselves. (See, for example, Richard Kluger's *Simple Justice* and Linda Greenhouse reporting on the Supreme Court for the *New York Times* for illustrations of this point.)

For these reasons, policy reforms that advance the public's health, such as the enactment of Medicare, stricter food and drug laws, school entry immunization mandates, or a judicial decision regarding the right of persons with disabilities to be free of medically unnecessary institutionalization, are a product of a processes in which evidence is presented, alternative approaches are identified and compared, and stakeholder interests are balanced.

Policy analysis is an ongoing process that is integral to decision-making. Even when the United States Supreme Court announces that a majority opinion is merely an interpretation of the text of a statute, regulation, or provision of the Constitution, no one should think that simply reading the words on a page and announcing what they say is what is really happening. Deciding *what* a statute actually says or means is the ultimate exercise in policy-making. No words are ever so clear as to be devoid of nuance and ambiguity; the words of public policy, in particular, are often steeped in underlying meaning. In deciding what words mean, courts are highly sensitive to the environment in which they operate, and legislators and rule-writers often rely on courts to give meaning and clarity to what they put on paper.

Think again of *Brown*, which overruled *Plessy v Ferguson*, a 50-year-old decision in which the Court had ruled that the phrase "equal protection of the laws" — the crux of the 14th Amendment to the United States Constitution — permitted legal segregation of the races. Only two generations later, a different Court concluded that the *very same words* could no longer be read to tolerate such conduct. The words of the Constitution were the same: it was the world that had changed, and the Court knew it.

Studying policy can be quite frustrating. Policy can seem eminently reasonable and fair, or irrational, arbitrary, and unfair. Regardless, the policy itself is an outcome of the policy-making process, which rests, in part, on a dynamic set of methods known as policy analysis.

learning objectives

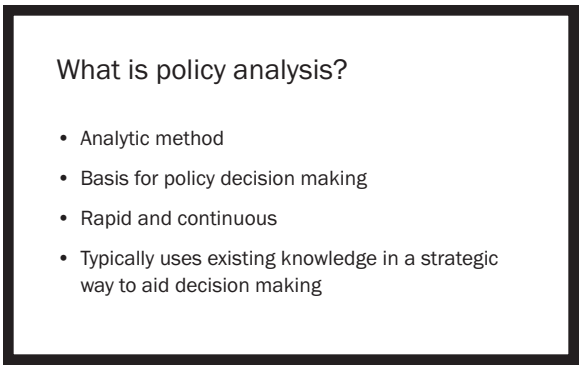
By the end of the lesson and completion of all assignments, students will be able to:

1. Apply the basic methods of policy analysis to public health policy problems in order to:
   a. Describe the ways in which framing an issue can profoundly affect the nature of the policy analysis and its outcome
   b. Create simple options
   c. Use basic criteria to compare options
2. Describe the key settings in which public health policy decision-making takes place, and the relationships of these settings to one another
3. Describe the fundamental categories of stakeholder interests that inevitably are present in public health policy-making
4. Describe how the policy-making process can affect the outcome
5. Explain the techniques used in the policy-making process to elicit stakeholder input
6. Differentiate between "policy analysis" and "policy advocacy"

key points to be made in lesson

1 What is policy analysis?

Policy analysis is a method undertaken to aid decision-making in a policy context. Policy analysis typically is not original research. Instead, it is a methodological approach that uses a special set of skills to find, assemble, and apply all existing knowledge in a strategic fashion in order to aid policy decision-making. The one exception to the general rule that policy analysis involves strategic synthesis and critical analysis rather than original research, is that policy analysis frequently does entail the development of original cost evidence, in the form of cost estimates tied to options for policy reform.

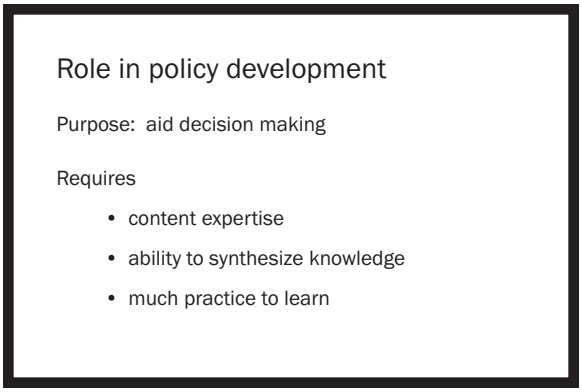


In contrast to traditional scientific research that can take years, policy analysis is rapid and continuous. Work typically must be completed in months at the most, and more often, within hours or days. The work also often involves dozens of separate analyses related to one problem, as the thinking about the problem evolves in light of changing political, economic, or social circumstances. Because the political and policy contexts continually change, often relatively quickly, repeated analysis within a short time frame can be an essential component of the overall process. It is not atypical to find that the process is never completed, but in fact is constant and evolving; as one policy gets put into place, other problems progress.

Also important is the critical link between program evaluation and policy. Since policy is always evolving, program evaluation, when done with an eye toward the policy horizon, becomes critical to informing policy development and policy analysis.

2 Policy analysis in relation to policy development

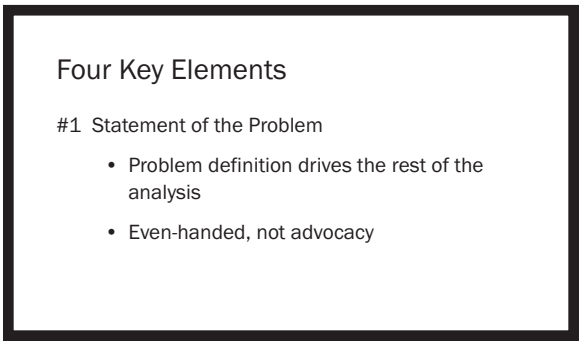
There is a cardinal rule in health policy analysis. The job is to aid the decision-maker, not to describe the problem *ad nauseam*. One of the most common errors made in learning to do policy analysis is to devote pages to lengthy problem descriptions. The gold standard of a great policy analysis is the use of rapid synthesis techniques that cull from a vast literature what a decision-maker must know, framing that knowledge within an overall statement of the question to be tackled, and accompanied by some options for addressing the problem. Learning to do policy analysis takes time.



3 The four key elements of policy analysis

A policy analysis consists of four key elements: the problem statement, background, stakeholder analysis, and options.

The problem statement is the most essential component as it will drive the analysis, including the background, the identification and analysis of stakeholders — the entities and individuals who have vested interests in the outcome, and whose political presence will be felt throughout the process — and the policy options.

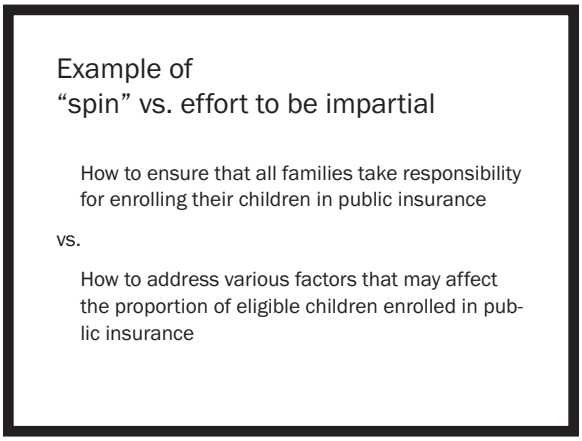


The policy statement becomes the most critical point in distinguishing analysis from advocacy, although there are those who argue that there is no such thing as an impartial and apolitical problem statement. An analyst will attempt to frame the issue so that many types of options can be presented, while an advocate for a particular approach will attempt to frame an issue in a way that leads to a particular solution or remedy.

For example, if the policy problem were stated as "options for insuring uninsured children," one might get a very different answer from options available if the problem were to be stated as "options for insuring all children stably and continuously, while avoiding further erosion in employer-sponsored coverage." The first problem statement leaves open all options, including a replacement approach to employer sponsored coverage. The second problem statement assumes the survival and preservation of an employer system, and is really aimed at creating a supplemental or companion form of coverage.

4 Four key elements, continued

Another example, again drawn from the world of child health coverage, involves the under-enrollment of low-income children in public insurance programs. One way to frame the question would be: "How do we ensure that all eligible families take responsibility for enrolling their children in public insurance?" This frame suggests that family behavior is the problem to be addressed. Another way of framing the issue, and one that does not pre-suppose the remedy, would be to ask: "What options exist to address the causes of under-enrollment in public insurance programs among eligible children?" This frame allows options that go to systemic and policy barriers, as well as questions of choice and behavior.

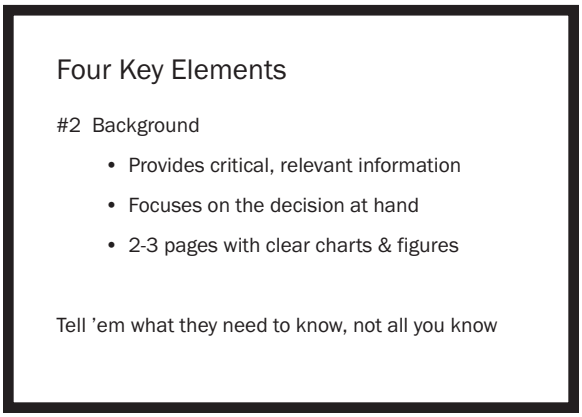


5 Four key elements: Background

The background section of a policy analysis is meant to be short and to the point. Superb analyses may take 1-2 pages to lay out the dimensions of a problem, the synthesis is that good. Beginners should shoot for three pages or fewer, always with an eye to *what it is a decision-maker would need to know in order to reach a decision*.

For this portion of the analysis, as well as throughout, the analyst needs to pay considerable attention to who the decision-maker is. If the decision-maker is a legislator, the facts may be very different and far more broad-brush than if the decision-maker is an agency head trying to decide what policies are needed to implement a particular aspect of a new program.

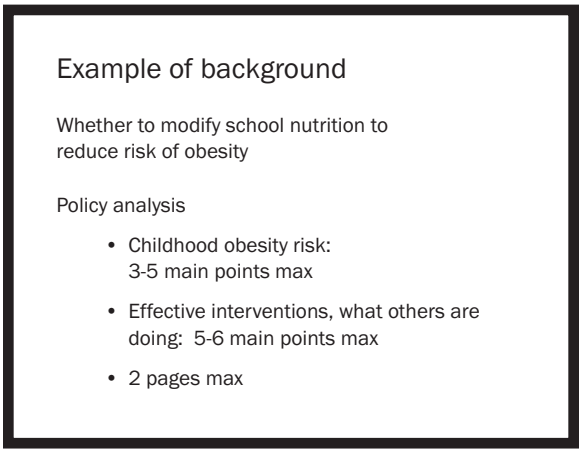
Sometimes, but not always, a simple chart or graph helps, depending on whether the decision-maker is someone practiced in the skill of reading and understanding pictorial evidence.



6 Four key elements: Background, continued

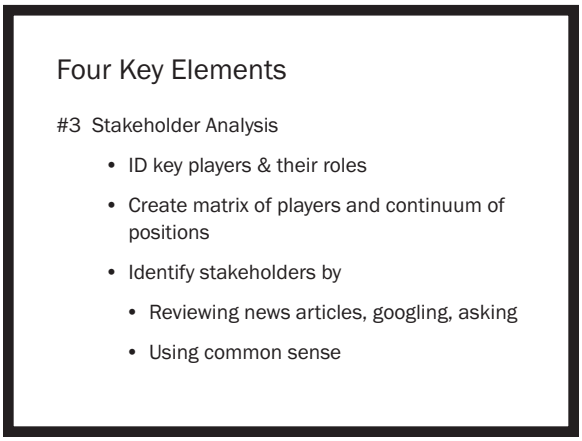
A good example is a school board that needs to decide whether to launch various types of obesity prevention programs in the school system. They do not need a book on childhood obesity (although providing a *separate fact sheet* with lots of obesity facts might be a terrific idea). Instead, they need the most salient points (e.g., relevant measures from their school system, trends in obesity, what experts say are the underlying causes, and the fact that research suggests that school may be an effective intervention point in a well-designed approach).

The job is to *synthesize knowledge for the policy-maker in an impartial fashion*, not to produce a book report on obesity. That said, an analyst may need to gather, read, and process an enormous volume of information in order to write three good pages. The gathering of information for an informed background can take time, and the ability to rapidly absorb and artfully summarize an enormous volume of data and evidence is also required.



7 Four key elements: Stakeholder analysis

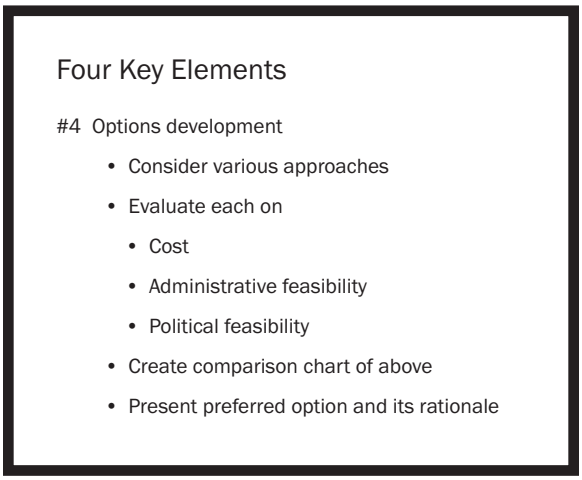
The stakeholder analysis is essentially an assessment of the political feasibility of one or more possible solutions. Do not be surprised to find that stakeholders object to every solution. This is where the art of policy development comes into play, as do the skills of the analyst and decision-maker. Much policy is the result of having successfully balanced or nullified all stakeholder objections and resistance. One of the most famous examples of the ability to understand and divine stakeholder positions well enough to "snake through" a policy solution was the enactment of Medicare, the national health insurance program for elderly persons and certain persons with disabilities. In his seminal study, *The Politics of Medicare*, Theodore Marmor recounts the approach taken by decision-makers to the development of the Medicare program, a combined approach that satisfied the interests of hospitals and physicians — the two gargantuan stakeholders of the day — and did so in a way that, to a remarkable degree, was able to meet a pressing social need.



How do we find out who are the stakeholders in any problem? Strategies include drawing upon word-of-mouth, conducting website searches, talking with decision-makers, reading the newspaper, and learning from other advocates who the key players are. And, do not forget about pure common sense. In a proposal to reform Medicaid, for example, state lawmakers would care as much as federal lawmakers, since the program is jointly administered. Additionally, health care providers that treat Medicaid patients would also be invested in reform. In another example, a proposal to alter environmental rules, stakeholders might include state and local officials, affected industries, and organizations that specialize in good, or *de minimus*, government (e.g., public interest advocates on both sides of the issue).

8 Four key elements: Options development

The final stage of the analysis is the creation of various approaches, often represented in a comparative tabular format. The options would be described; their cost and political, and practical feasibility assessed; and critical stakeholders identified. Comparative analyses can be elaborate or quite simple, but a side-by-side approach allows the decision-maker to compare options all at once. This technique also permits the analyst to more easily highlight strengths and limitations.



9–10

An actual example

[*These slides are meant to guide open discussion. Any policy problem can be inserted in their places, as long as the discussion covers issue framing, background development, stakeholder analysis, and options.*]

Example 1

Health insurance coverage for children

At issue:
Federal coverage for children from low to moderate income families ineligible for Medicaid

Example 2

Vaccines

At issue:
Should state agency mandate vaccination against HPV for 9- to 11-year old girls as condition of school enrollment?

Example of Policy Problems: Health Insurance

1 Congress is developing legislation to extend health insurance coverage to low- and moderate-income children who are not eligible for Medicaid, but whose families also have no access to affordable coverage. How much should lawmakers subsidize the cost of premiums, which, without a subsidy, might be several hundred dollars a month? What is the issue that policy-makers need to decide? Is it how many subsidy dollars to provide to each family, or is it what level of subsidy is needed in relation to family income, in order to make coverage affordable? What facts would a policy-maker want to know as part of the background for decision-making? Who might the stakeholders be who will influence the process? Is it families? How about the insurance industry that sells affordable products to low income families? Or, how about the health care professionals who provide pediatric care to families? What might some options be for making a decision regarding the subsidy? Where might a policy analyst look for background, stakeholders and their positions, and options?

2 A state health agency must determine whether to recommend adding vaccination against human papilloma virus (HPV) to the state's schedule of mandatory vaccinations for all 9-11-year-old girls as a condition of school entry. A new vaccine is on the market and is fraught with controversy because of its cost of nearly $500 for a complete series, the very public and aggressive lobbying campaign being mounted by a drug manufacturer at a time when people are increasingly sensitive to drug prices, and major opposition from groups concerned that the immunization will encourage premarital sexual activity among young girls. The agency head has only days to formulate policy for decision-makers. Because the vaccine has come on the market just weeks before the legislative session begins, proponents and opponents alike are already lined up, and tensions are high. Where does the head of health policy go for impartial information? Where might she look for options that have been developed to "thread the needle" with respect to controversial treatments (note: this is not the first controversial vaccine)? How much should cost play into her analysis?

discussion questions

The discussion questions in health policy work best if one presumes a particular policy problem and then builds the questions around the problem. Instructors should identify an issue and then use these questions to prompt class discussion:

A Who would be the major decision-makers in any particular policy problem?

- Distinguish between state and federal decision-makers in health policy problems
- Identify questions for the administrative, versus the legislative, process. For example, creating a new program is the province of a legislature, which must outline its elements and appropriate funds. How to administer an established program is typically the province of a public agency, such as a state or local health department.
- Discuss the role of courts in deciding major issues in public health policy. Focus on a controversial court decision about which passions are aroused on all sides. Read the decision and discuss what facts in the case were particularly important in explaining why a majority of the court decided the case as it did.

B Who are the stakeholders in any particular policy problem?

- Who are the potential winners and losers?
- Who are the key advocates and activists representing the various viewpoints, and what are their respective positions?

C Framing the policy question

- How many different ways can a policy question be framed?
- How does the manner in which the question is framed affect its outcome?

D Developing and comparing options

- What might be a range of options for any particular policy problem?
- Who among the key stakeholders are the winners and losers under each option?
- How big a role should cost or political feasibility play in determining an option?

E Knowledge for policy analysis

- How knowledgeable does an analyst need to be about any particular problem?
- How might an analyst quickly go about the task of learning enough to frame an issue, provide a relevant and informative background, and identify and compare options?
- Where might an analyst go to attain such knowledge?
- How would the analyst distinguish between impartial assistance and being "spun" by a policy stakeholder?

skills-building exercise

First, choose a problem that is the type that lends itself to a policy analysis within a legislative setting. Examples might be whether to rezone a particular community to require more green spaces, to mandate HPV vaccine as a condition of school entry for pre-adolescent girls, or to require near-poor families pay a premium for enrolling their children in Medicaid or the State Children's Health Insurance Program (SCHIP).

Next, divide the class into stakeholder groups and have each prepare a presentation that explains how their stakeholder might define the problem to be solved, what the stakeholder's position might be at a public hearing, and what evidence they would present to argue for their policy position.

Have the groups reassemble, but this time as chief analysts for the Chair of the Committee that will make a decision. Their task will be to determine how ultimately to frame the problem for the decision-maker, compare and contrast each stakeholder interest for the decision-maker, and come up with options that balance the competing interests.

assignments

1 Attend a legislative hearing at which stakeholder testimony is being presented.

2 Attend an appellate court argument at which competing sides present their views in briefs and oral arguments to judges.

3 Pick a hot topic of the day and collect at least five different news stories covering the topic that bring out different stakeholder points of view.

4 Develop a hearing for a legislative committee, including identifying the issues the committee wants to hear, competing testimony about the given problem to be solved, and a list of interests from stakeholders whom the committee wants to hear.

5 Select a particular problem, and search on the Internet for at least 10 groups with different points of view, examine their materials and describe how they frame issues and present options.

6 Select a topic of interest. For this topic, find at least two examples of relevant legislation or regulations, or a relevant decision from the highest court in the state. This exercise is meant to acquaint students with original policy documents, including how to search for, and read them. Of particular value are cases from a state Supreme Court that either uphold a public regulation against a challenge, or strike it down. Many such cases do not deal with the merits, but instead find that a particular agency did or did not have the power to write a rule, or that a particular challenger did or did not have the right to bring the case to begin with. This type of decision allows a rich discussion of the ways in which the policy-making process can decide without deciding, as in *not* issuing a rule, or by tabling a piece of legislation. It also underscores the importance of keeping policy disputes out of the judicial process, which while an option fundamental to fairness in society, is also inherently un-democratic and is meant to be used sparingly and only when the democratic process fails in some way.

possible guest speakers

- Staff to a city council member or a state legislator
- A staff person from a congressmember's home office
- A clerk for a judge
- An analyst who works for an advocacy organization and who uses policy analysis skills to advance a particular position

required reading

Chapter 1, "The Market and the Polis," in Stone D. *The Policy Paradox: The Art of Political Decision Making*. WW Norton and Company: New York. 2001.

suggested reading

Bardach E. *A Practical Guide for Policy Analysis: The Eightfold Path to More Effective Problem Solving* (2nd ed.). CQ Press: Washington, D.C. 2005.

Bergman AB (Ed.). *Political Approaches to Injury Control at the State Level*. University of Washington Press: Seattle. 1992.

Birkland TA. *An Introduction to the Policy Process. Theories, Concepts and Models of Public Policy Making* (2nd ed.). M.E. Sharpe: Armonk, NY. 2005.

Kingdon J. *Agendas, Alternatives and Public Policies*. Addison Wesley Educational Publishers: New York. 1995.

Kluger R. *Simple Justice: The History of Brown v Board of Education and Black America's Struggle for Equality*. Knopf: New York, 1976.

Marmor T. *The Politics of Medicare* (2nd ed.). Aldine Transaction: Piscataway, NJ. 2000.

Redman E. *The Dance of Legislation*. University of Washington Press: Seattle. 2000.

Rosenbaum S. The Impact of US Law on Medicine as a Profession. *Journal of the American Medical Association*, 289:1546-56. 2003.

Wing K, Mariner W, Annas G, and Strouse D. *Public Health Law*. LexisNexis/Matthew Bender. 2007.

other resources

The most critical reading perhaps in health policy is the "grey literature," the documents and analyses that outside stakeholder groups prepare regarding how they want an issue to be framed, and what they see as a policy solution.

In addition, some websites with excellent policy analysis information or examples of policy analysis and advocacy include:

The Kaiser Family Foundation (www.kff.org)
Materials on a broad range of health policy issues.

The Commonwealth Fund (www.cmwf.org)
Analyses of the health system with both population health and health care issues, as well as international comparative analyses.

Center on Budget and Policy Priorities (www.cbpp.org)
A key policy advocacy group in Washington D.C. working on many policy issues of public health import.

The American Public Health Association (www.apha.org)
Analyses and policy briefs on key public health issues.

The Congressional Budget Office (www.cbo.gov)
The definitive source of policy analysis, including cost analyses, for Congressional policy-making. Of particular interest might be CBO's annual options analysis for reducing the federal budget deficit.

5

Advocating for Policy Change

introduction

This lesson focuses on advocacy, the world of health policy advocacy, how advocacy is done, and what part you can play. The lesson reviews and explains working with administrative agencies, legislative bodies, the courts, ballot measures, the private sector, and public pressure to create or preserve health policy. This lesson also covers the practical aspects of and tools used in a campaign for health policy change: research and analysis, building support, strategic planning, and communications. The roles of those involved in the making of policy — including community groups, elected officials and their staff, CEOs, lobbyists, organizers, researchers, agency staff, professional groups, trade associations, media, lawyers, and health policy experts — will be discussed and explored. Overall, this lesson explains the basic steps involved in an advocacy campaign to advance the public's health.

learning objectives

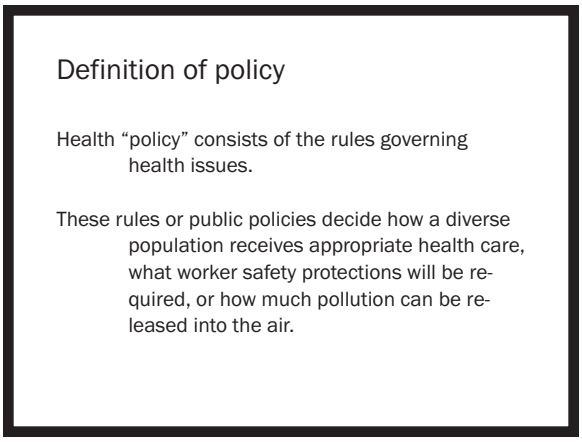
By the end of this lesson and completion of all assignments, students will be able to describe the importance of health policy, the components of policy change, and how advocacy campaigns are conducted. Specifically, the lesson will help students to do the following:

1. Clarify how advocacy can help improve the public's health
2. Identify strategies to affect agency actions to improve the public's health
3. Identify effective strategies to advocate for better health policies

key points to be made in lesson

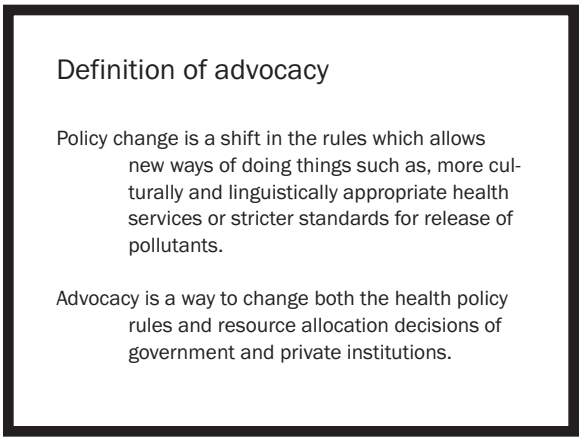
1 Definition of Policy

Health policy consists of the rules governing health issues — for example, requirements for culturally and linguistically appropriate health services, worker safety practices, or limits on air pollution. These rules or public policies decide such things as how a diverse population receives appropriate health care, what worker safety protections will be required, and how much pollution can be released into the air.



2 Definition of Advocacy

Policy change is a shift in the rules that allows new ways of doing things, such as health services that are more culturally and linguistically appropriate, stronger measures to prevent repetitive stress injuries, or stricter standards for release of pollutants. Policy change for its own sake is not a goal; if a policy does not improve a public health system or community's environment, its passage is not a public health victory. ***Advocacy*** is a way to change both the health policy rules and resource allocation decisions of government and private institutions. This lesson will help students identify and learn the skills they need to conduct advocacy campaigns, including who the changes will serve and how to present an effective case.

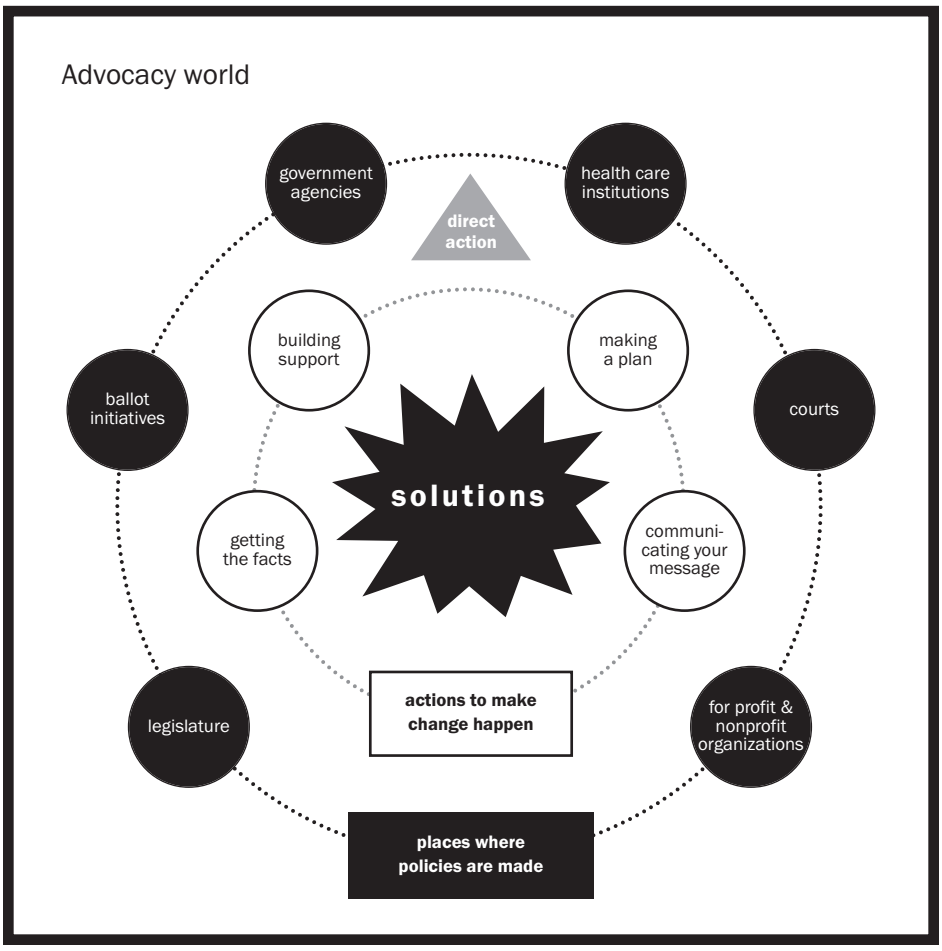


3 The Advocacy World

Advocacy can be done in many ways, including: seeking changes in government agency policy or practice, working with private businesses or health care institutions, changing laws, introducing ballot initiatives, taking direct group action, and when necessary, litigation. The illustration *advocacy world* provides a way to visualize and understand the parts of any advocacy campaign and how they work together. The Elements are the steps to making change happen: getting the facts; building support; making a plan; and communicating your message. The Forums are the places where advocacy decisions are made:

- Changing the Law
- Working with Government Agencies
- Working with Private Companies
- Using the Ballot Box: The Initiative and Referendum Process
- Using the Courts
- Direct Group Action

Think of this as a template to plan your advocacy work.



4 Elements of change

Advocacy can be done in many ways and in many forums, and often, one or more of these strategies is used to bring about better health or to protect what is now working effectively. The same advocacy elements are used in every advocacy forum. However and wherever health advocacy work is done, there are four elements common to all policy advocacy work.

Elements for change

- Getting the facts and analysis: research
- Reaching out: organizing and coalition building
- Making your plan: develop goals and strategies
- Building support: communicate your message

5 Getting the facts: research and data collection

To improve public health you will be asking the public, the media and decision makers to rely on what you say and then to take the action you recommend for solving the problem. You must know all you possibly can about the situation you want to change, including viewpoints on all sides of the issue, in order to give a complete and accurate picture. *[Instructor: see Lesson 4 on Policy Analysis.]*

Getting the facts: research

You can find out more through:

- Organizations, community members and individuals who have been affected. Also, explore the position of potential opposition to develop effective counter-arguments
- Books, newspapers and periodicals
- The Internet
- Government information through a federal Freedom of Information Act (FOIA) request or state Public Records Act (PRA) request
- Academic sources
- Data sources and research organizations

- Academic Sources: Schools of Public Health, and other academic institutions can provide a great deal of unbiased research and analysis to help you clarify a problem and identify solutions.
- Data Sources: There are research organizations, and data sources that are intended to be helpful and accessible to community groups. They can direct you to search engines and other sources for finding information relevant to your community's health issues. State-based resources such as the California Health Interview Survey and nationally-focused organizations such as the Urban Institute's Health Policy Center are good places to start. *[Instructor: see Other Resources for URLs.]*
- Information on Policy Analysis includes sources such as: The California Health and Human Services, Office of the Secretary; UCLA Center for Health Policy Research, and; California Health Advocate's Resources.
- Books, newspapers, and periodicals: Read the available literature on the problem and its history, not only to know everything you can, but also to identify experts who may be helpful and individuals who may be part of the problem.
- The Internet: A search of the World Wide Web may uncover information about your problem and links to organizations on the same issue in other sites.

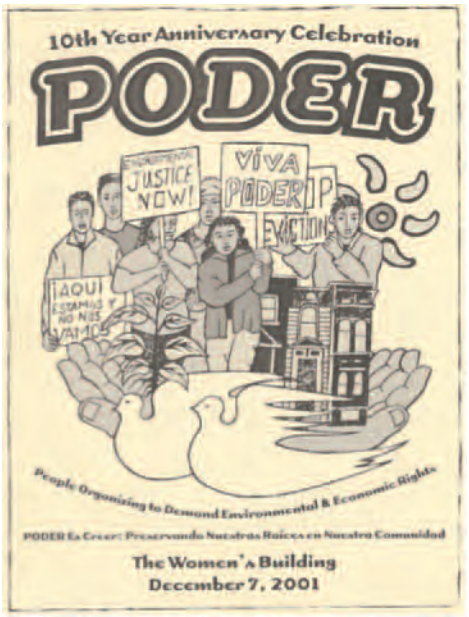
- Government reports and documents: Your efforts will gain credibility if they are supported by information from government sources. A credible campaign makes it difficult to deny that a problem exists. You may have to file a Freedom of Information Act (FOIA) or Public Records Act request to get the materials you need.
- Organizations and individuals—It is extremely important to learn the views of other organizations and individuals interested in health issues. You'll want to confer with like-minded individuals and organizations, not only to get the benefit of their experience, but also to enlist their support. You should also explore the positions of potential opponents, not only to better understand their perspectives, but also to help you incorporate effective arguments against their positions into your action and your media materials.

6 Example: PODER: getting the facts on lead

In 1992, PODER, a grassroots group organizing families for environmental and economic justice in the Mission District of San Francisco, realized that many children were suffering from lead poisoning. They did research and found studies that showed lead-based paints were often the cause of lead poisoning in children and that many homes in the Mission District were older and contained lead-based paint. Using this information, along with other data and local surveys, they were successful in getting a comprehensive Environmental Lead Poisoning Prevention law and program for all of San Francisco.

Getting the facts: PODER

PODER successfully persuaded San Francisco's Board of Supervisors to adopt a lead abatement ordinance



7 Building support: organizing and coalition building

A single individual or organization can take action, but the likelihood of success is far greater if a coalition of groups and individuals join in the work. The success of a coalition depends on many factors, and is strengthened by adherence to basic coalition principles. *[Instructor: Discuss coalition principles; see Lessons 6 & 7 on Community Organizing and Coalition Building.]*

Organizing and coalition building

Organizing
: is the work you do to educate and inspire others in the community concerned about health to support and join in solving problems.

Coalition building
: is the work you do to reach out to diverse groups and organizations to participate in a coordinated effort to identify and solve health problems.

8 Making a plan: develop goals and strategies

Every advocacy campaign to improve health, whether it is a national, statewide or local effort, requires a plan to get from the problem to the solution and includes a road map of the steps to be taken along the way. *[Instructor: Discuss four elements.]*

Making Your Plan

"If you don't know where you're going, you'll probably end up somewhere else."

A plan that moves from the problem to a solution:

- Clearly defines the problem
- Clearly defines the solution and interim goals
- Assesses the available resources
- Develops a clear strategy based on your chosen forum(s)

9 Communicating your message: informing the public and decision-makers

Your campaign will need to influence the public and decision-makers. The challenge is to craft a way to communicate your concerns and goals so that they are understood and believed, and move people to take the action you seek. *[Instructor: Discuss four foundations for successful communications; see Lesson 8 on Media Advocacy.]*

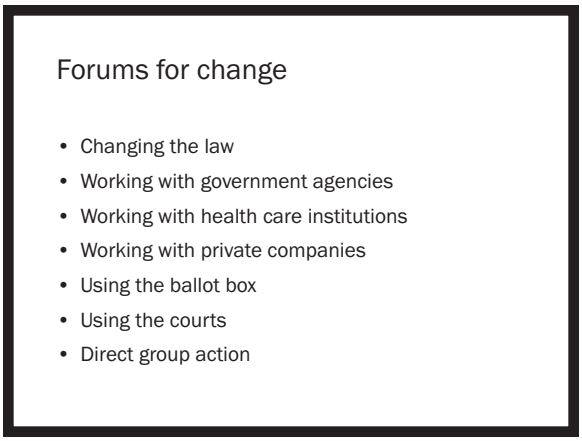
Communicate

Four foundations for successful communications:

- Accurate facts & respected analysis
- Broadly acknowledged value
- Simple and compelling story
- Reach the right audience

10 Forums for change

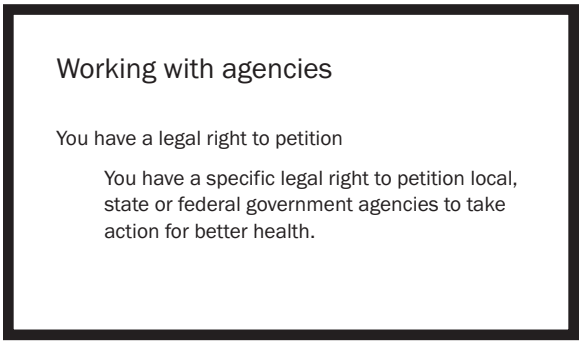
Advocacy strategy starts with where the campaign will focus its efforts to change the rules — that is, what forum will you use to bring about change? Each Forum has advantages and disadvantages. For example, a plus for Changing the Law is that legislators and local legislative officials are elected and, at least theoretically, accountable to voters. But a drawback is that drafting and passing legislation is a highly political process. Elected officials will weigh how their actions might help or hurt their standing with voters, campaign contributors and supports. Working with Government Agencies can be a plus since agencies typically have broad authority to act "in the public interest," they can address actions that are harmful but not necessarily illegal. A minus is that since agency heads are appointed by the executive branch and subject to oversight by the legislature, they are still subject to political pressure. *[Instructor: ask the class to suggest pluses and minuses for each Forum.]*



11 Petitioning Administrative Agencies

To supervise our increasingly complex society, state legislatures and the U.S. Congress, as well as county boards of supervisors and city councils, have created units of government called administrative agencies. These agencies are given a name, official powers, personnel, a budget, and, most importantly, a mission. Agencies may be directed to clean up the environment (Environmental Protection Agency), safeguard children (Department of Child Welfare), regulate Health Maintenance Organizations (Department of Managed Health Care) or secure other goals that promote the health and welfare of the public.

Most agencies are headed by an official who is appointed by and serves "at the pleasure" of the President, Governor, or mayor, meaning he or she may be removed at any time. To promote independence, some agencies (such as the Federal Trade Commission and California Public Utilities Commission) are headed by a multi-member body whose members are appointed for a fixed term. At the local level, voters often elect the board members for school, utility and hospital districts.



Both the U.S. and California constitutions give the public the right to petition government for the redress of grievances. In addition, Congress and the California Legislature have passed laws that specifically give the public the right to petition administrative agencies for rulemaking action.

This means anyone can petition any government official, agency, board, department, or other unit of government at any level. Usually, we think of redressing our grievances by filing lawsuits (the judicial branch) or lobbying for new laws (the legislative branch). The Administrative Petitioning process involves the third branch of government (the Executive Branch). Often it is a less difficult and less expensive approach than a lawsuit, and less political than legislation.

Through skillful use of the Administrative Petition, we can improve the health of people in our communities. Instead of helping people with the same problem one person at a time, the petitioning process is a broad-based public health approach that can help large groups of people by addressing the problem on a community-wide or even statewide basis. The Administrative Petitioning Process is not about helping just one client or family member but about changing the system to help every person in that situation. It is an important tool to pursue your advocacy goals.

12 Administrative Petitions: format and process

For most agencies, there is no special form for administrative petitions. The contents of a petition, of course, will vary from issue to issue and agency to agency, however, all petitions should:

1. Explain the problem and describe how the public is being harmed;
2. Discuss why the agency is responsible for solving the problem; and
3. Propose the actions that the agency should take.

All petitions include an introduction; a statement of facts about the problem; identification of the individuals and organizations submitting the petition; the legal authority for agency action; the solution sought; a conclusion; and supporting exhibits (if necessary). The cover letter, addressed to the head (or heads) of the agency, should briefly explain the reasons for the petition without rhetoric or sensational language and urge the agency to take prompt, effective action. When the petition and cover letter are in final form, advocates file them with the appropriate agency. Filing simply means delivering the documents to the appropriate person at the agency. Note that the filing can be an opportunity to bring public attention to the policy solution since filing is a public act. For example, the Center for Digital Democracy often announces on its blog and alerts reporters when it files petitions with the Federal Trade Commission or other agencies.

Working with agencies

What is a petition?

- An administrative petition is a specific legal tool that your community can use to make a formal request that a government agency take action to protect and improve community health
- A petition can also be used to focus community demands that a private organization, like a hospital or business establishment, change its policies

Keep in mind that you can petition an agency even if it has not adopted any specific rules regarding petitions. For example, Consumers Union and 24 other community organizations petitioned the Department of Corporations (DOC) to promulgate and implement regulations governing the conversion of a nonprofit health maintenance organization into a for-profit business.

The petition was written in a legal format, and although the DOC had no specific procedure to petition for rulemaking, these groups titled their request an "Administrative Petition" and presented the case just as they would for any other petition. In response, the DOC began formal proceedings, including public hearings, for the approval of the transaction. The result of the hearing was the creation of two private foundations, endowed with over $4 billion, dedicated to addressing health needs in California. The petition by Consumers Union and 24 other groups was only eight pages long.

While it is relatively easy to create and file a petition with an agency, it should not be assumed that it is easy to obtain the regulatory outcome you desire from the agency. But, there can be positive results that are informally achieved by having engaged in the process. For example, in the mid-1990s, some handgun makers began to advertise their products in magazines, suggesting that having a handgun in the home was protective of those residing in the home. The epidemiologic evidence was to the contrary — having a gun in the home increased the risks of homicide and suicide for those living there. Public health policy experts in the area of gun violence prevention petitioned the Federal Trade Commission to prohibit these advertisements, on the grounds that they were deceptive under the law. Substantial publicity accompanied the petition. While the FTC never formally acted on the petition, the gun makers decided to discontinue such advertisements.

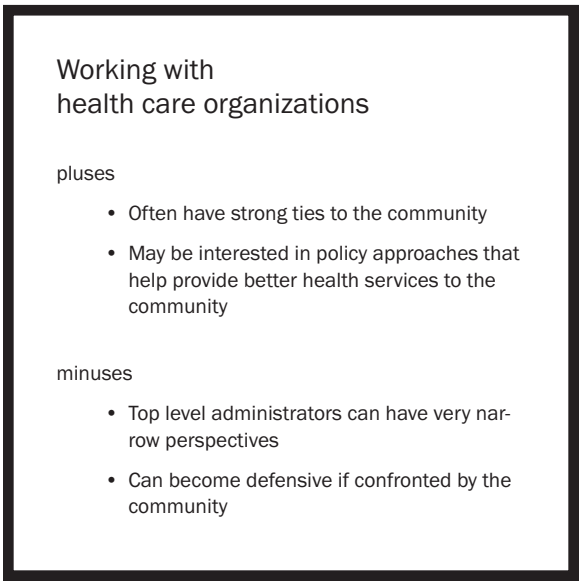
It is also possible to get government agencies to act without having to resort to the formal petition process. In Baltimore, Maryland, gun violence prevention experts were concerned that local stores were selling individual bullets to youth in areas where there were high homicide rates. Working with the local health commissioner and chief of police, sting operations documented such illegal sales to minors, and the health commissioner closed the offending vendors. Re-opening of the stores was conditioned on reformed sales practices of ammunition, with stringent record-keeping requirements.

13 Working with health care institutions

A plus for working with health care institutions' stated goal of providing quality health services for community provides a lever to encourage policy change to better those services. A minus is that decision makers can be very defensive and close minded when told that their institution is failing to meet the community's needs. Health care institutions set policies and practices in response to laws and regulations, but also independently. These polices can determine how health care institutions operate, and can include, for example, the quality and level of services provided or who has access to such services. Health policy change can take place in hospitals or health plans as well as in regulatory of accreditation bodies or professional organizations.

Health care institutions can be a part of the government (e.g. a county Department of Health Services) or they can be in the private sector. Private sector health care institutions can be nonprofit organizations-including providers (e.g. Kaiser), medical associations (e.g. California Medical Association), or regulatory bodies (e.g. Joint Commission on the Accreditation of Healthcare Organizations) or for-profit enterprises, such as a health plan or pharmacy.

Whether the decision maker is responsible for a government health care provider or a private health institution, you need to take the same steps to make change happen. With facts, support, planning and communication, these institutions can be persuaded to change their systems and improve your community's health care.



14 Working with private companies

Private businesses have an enormous stake in improving public health. In the case of health care reform, for example, many businesses either provide or would like to provide health insurance coverage for employees and their families. Other businesses, such as pharmaceutical manufacturers, managed care companies, hospitals and nursing home chains provide the products and services that make up our health care system. Other private companies provide products that have an enormous impact on health: food, alcohol, tobacco, cars, etc. In these cases advocates may work with — or against — the companies. In some cases, industries are more driven by short-term, bottom-line concerns than the long-term health and survival of their consumers. Advocates can work more effectively with the private sector when they take time to understand for-profit business incentives.

Working with business

pluses

- Since its public image is a very valuable asset, a business may be especially willing to help address a specific problem if that enhances its image
- Large corporations have a lot of resources that could be enormously helpful in bringing about change

minuses

- Every business is a for-profit entity. Typically, businesses will oppose proposals that might harm their economic interests, support proposals that further their economic interests, and be indifferent to proposals that do not affect those interests.

15 Using the ballot box: initiative and referendum process

In California, the Constitution gives voters the power to adopt new laws by initiative and repeal existing laws by referendum. The charters of many local governments also provide for direct lawmaking by voters through the initiative and referendum process. Health care and consumer activists have used he initiative process to pass measures that have been blocked in the regular legislative process. For example, health advocates in California successfully passed a tobacco tax proposal that repeatedly failed in the state legislature. In most cases, sponsors of an initiative need to collect a minimum number of signatures to have the proposal put on the ballot, and at least 51 percent of the voters who show up to the polls must vote "Yes" for it to pass. In a state the size of California, initiative campaigns can be very expensive.

Using the ballot box

pluses

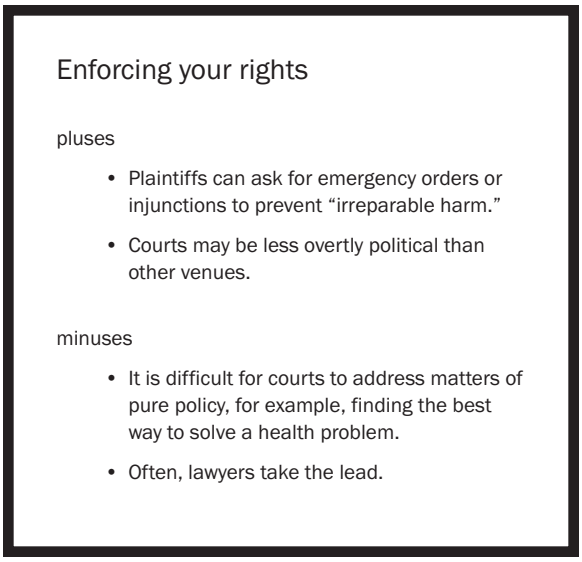
- The initiative process can circumvent the regular legislative process and tap into public outrage about a problem.
- Some initiatives (typically on social issues) do not draw any opposition or require a huge expenditure of money.

minuses

- Often voters are not sympathetic to complicated measures, spending additional tax dollars or passing new laws.

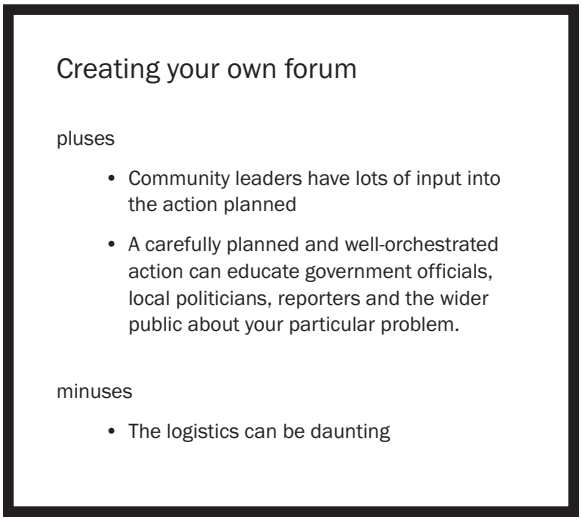
16 Enforcing your rights: using the courts

One method to bring about change is to file a lawsuit. Sometimes lawsuits are brought to stop actions that violate existing law(s) or to require actions that are mandated by existing laws(s). Another powerful use of litigation is suing the makers of unsafe products or places, so that the cost of injury or illness incurred by others is transferred back to those who can more safely redesign the product or place. For many years, air bags in cars were not made available to the public, even though it was understood that they could save many lives. When a suggestion was made to trial lawyers that they sue the car makers, on behalf of their injured clients, for failure to offer air bags, the economic burden of such lawsuits helped to force car makers to install air bags in their vehicles. Lawsuits involving other products have convinced manufacturers that it is prudent to invest in prevention, rather than paying the penalty for neglect.



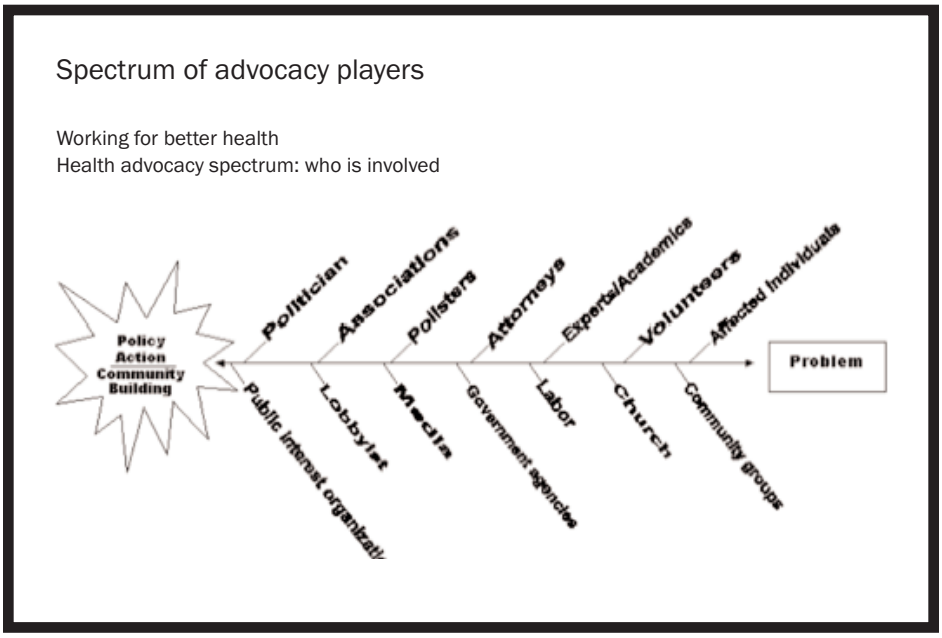
17 Creating your own forum: direct group action

In some cases it may be necessary to take direct group action to focus public attention on an issue. For example, if filing a lawsuit or going to the legislature is not feasible, you might explore whether a respected local institution (e.g. League of Women Voters, PTA, newspaper, community clinic, church or union) would sponsor a public hearing on the issue. Ideally, the sponsoring institution would work closely with community leaders to schedule the hearing; invite speakers, elected officials, policymakers, and the media; plan the agenda; and actually convene and chair the hearings. The success of taking direct group action will often be judged by the number of people who turn out, the importance of the participants, and the general seriousness of the event.



18 Spectrum of advocacy players

Health policy decisions are made in many places by many individuals and institutions. They are made by elected and appointed officials who serve in local, state and federal governments. They are made by the courts and by people themselves through the ballot box. They are also made by private sector organizations such as health plans, hospitals and corporations. You must identify which decision maker can best address the problem you have identified.



19 Advocacy principles: guidelines for success

Health policy advocacy builds on many skills you now have. Success requires creativity, hard work and perseverance. It can all be a bit easier if you keep the list of advocacy principles in front of you as you advocate for better health solutions. *[Instructor: Discuss basic personal principles including work principles, campaign principles, and sustaining principles]*

Advocacy principles
Guidelines for success

Basic personal principles

- Factual accuracy
- Total honesty
- Responsible tone (keep inflammatory rhetoric in check)
- Respect confidences

Basic work principles

- Work within a coalition
- Define the problem
- Have a plan with defined interim goals and final goals
- Include community building
- Be flexible about strategies
- Don't humiliate opponent

Basic campaign principles

- Frame the issue—tell a story
- Stay on the offensive
- Raise the stakes
- Stay on mission — don't get sidetracked
- No party politics

Basic sustaining principles

- Maintain perspective
- Have 3 to 5 key advisors
- Have a life
- Never think it's over
- Never quit

20 Example: Aventuras para Niños

Aventuras para Niños (Adventures for Children) was a 2002–2007 community-intervention trial in southern San Diego county that tackled the environmental factors contributing to childhood obesity. The campaign worked to change the home, school, and community environments of Mexican- American children, who are disproportionately affected by the obesity epidemic, to increase their opportunities for physical activity and healthy eating.

Aventuras used *promotoras*, women from the Mexican-American community who were trained in basic health promotion. This model takes advantage of the community's existing social networks through which health information is exchanged and environments are created, and has been shown to be particularly effective and culturally appropriate in Latino populations. Improvement of local parks to make them more accessible and attractive to local families was one of the first community goals identified by *Aventuras* staff and the *promotoras*. Four parks in the community of San Ysidro on the U.S.-Mexico border were in particularly bad condition, with broken playground structures, non-functioning and graffiti-covered water fountains and bathrooms, and poor lighting. Two *promotoras* took photos of the parks, interviewed families, and collected more than 300 signatures on a petition for improvements. They presented their findings to the San Ysidro planning and parks committees and obtained a letter of unanimous endorsement from the San Ysidro Planning and Development Group. After the *promotoras* met with city council staff several times during 2005 and prioritized one park in particular, the San Diego Park and Recreation Department made site visits to the four parks and prepared estimates for upgrading. The city eventually committed to paying for the park improvements in October 2006 and began construction in July 2007. Thus, while no permanent commitment to increasing funding for additional park improvements occurred, over $430,000 of public revenue was secured for much-needed park improvements in highly disadvantaged community within San Diego.

Aventuras para Ninos
(Adventures for Children))

- Community intervention trial on obesity
- Focus on environmental change for Mexican-American children
- Used promotoras -- women from the community trained in health promotion
- Secured significant investment in neighborhood parks

21 Restrictions on legislative advocacy

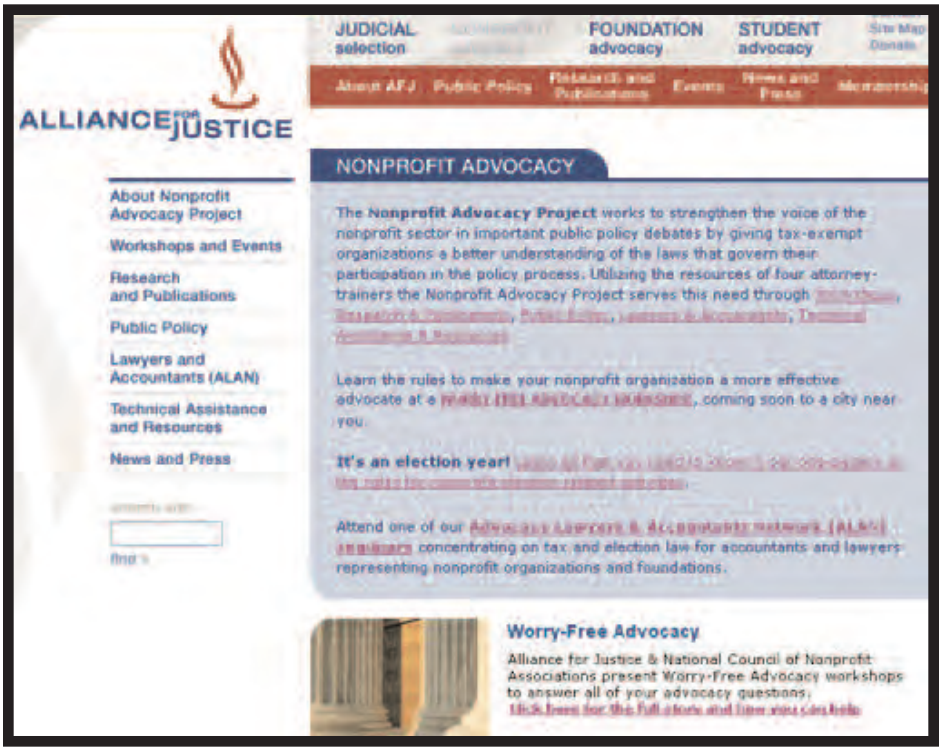
"Lobbying" has come to mean trying to convince someone to do something, such as "lobbying" a friend to go to your favorite restaurant or "lobbying" the mayor to open a clinic in your community. However, under IRS definitions there are certain restrictions on two types of lobbying by 501 (c) (3) organizations. There are annual limits (depending on the size of the organization) on the amount of money that can be spent on direct lobbying and grassroots lobbying. The three elements of *direct* lobbying are:

- Expressing a point of view on a specific piece of legislation,
- Direct communication to a legislator, their staff or another involved government employee,
- Requesting an action (such as, support, oppose or amend this bill).

Grassroots lobbying expresses a point of view on a piece of legislation and seeks to influence others to take action, like writing to their Senator to oppose a specific bill. It is important to understand that these restrictions do not apply to the many other forms of health policy advocacy such as creating public pressure, organizing and building community support, talking to the staff of an agency like the Department of Health, or describing a problem to the mayor.

It is also important to understand that the restrictions on lobbying are not intended to prevent legislative advocacy or lobbying. The Alliance for Justice points out that Congress has stated that influencing legislation is an appropriate and legitimate activity for charitable organizations. In 1976, it passed legislation giving public charities the right to lobby up to defined percentages of their annual expenditures.

There are many ways for 501 (c) (3) organizations to lobby or advocate in legislatures without violating IRS rules. In order to find out more regarding the specific restrictions, The Alliance for Justice has published *Worry Free Lobbying for Nonprofits* and other materials that clearly describe the guidelines for 501 (c) (3) organizations to follow when advocating in the California legislature or in Congress. *[Instructors should investigate and discuss the specific rules in their state. See Other Resources for URL.]*



discussion questions

1 What public health problems or situations could be best solved with administrative advocacy (e.g., petitions), and which problems are more suited to changing institutional, local, state or federal laws and policies?

2 How could you get various stakeholders to agree to work together on policy? What could you do when the policy solution may be incremental and so for some groups, not go far enough?

3 How would you gather evidence to support your policy position?

4 What could you do to get policy makers' attention?

skills-building exercise

Planning for Advocacy: The class exercise allows students to practice tasks that will help them organize their research, writing, decision-making and actions. Ask students to work in small groups to answer the questions on the Understanding How to Impact Health Policy Worksheets. Students should present the class with a summary of their findings and strategy to move health policy into action. Different groups should discuss the plan presentations in terms of their pluses and minuses.

Drafting Administrative Petitions: Ask students to use the Petitioning Worksheet, Blank Administrative Petition, and Quick Reference Checklist in small groups to create a plan for filing an Administrative Petition. Students should be able to describe the elements of an Administrative Petition and explain how the work required for developing an Administrative Petition is necessary for any advocacy campaign. The small groups should draft facts supporting key elements for the campaign and develop a compelling argument for the policy change. Once the small groups have completed their work, conduct a role play in which one person from each group presents the group's petition to the head of the agency or institution that is being petitioned.

assignments

1 Draft an advocacy plan. Students will pair up and identify an existing health policy issue they feel needs improvement. Using the Skill-Building Worksheets, students will demonstrate learned skills of health policy research and analysis to draw up an advocacy plan that can be used to enact the improved health policy.

2 Draft an Administrative Petition. *[Instructors can use the blank Administrative Petition provided with this lesson.]*

possible guest speakers

- Public health leaders of policy campaigns
- Elected officials or other lawmakers
- Administrators and regulators
- News reporters and editors

required reading

Advocating for Change: Understanding How to Impact Health Policy, Oshiro and Snyder, with assistance from Matt Iverson, published by the Health ExChange Academy of the Center for Healthy Communities of the California Endowment, 2006.

Advocating for Change: Persuading Decision Makers to Act for Better Health, Oshiro and Snyder, with assistance from Matt Iverson, published by the Health ExChange Academy of the Center for Healthy Communities of the California Endowment, 2006.

Getting Action: How to Petition Government and Get Results, Snyder H, Yoshiro C, Holton R. 2002. Available as a PDF for download at:
http://www.consumersunion.org/other/g-action1.htm

The Democracy Owners' Manual, A Practical Guide to Changing the World, Shultz J. Rutgers, University Press: New Brunswick, NJ. 2002.

suggested reading

Bell J. Learning to Lobby: Steps to Successful Legislative Advocacy. *Race, Poverty and the Environment*, Vol. 10 No. 2, pp. 41-45, Fall 2003.

California Senate Rules Committee. How a Bill Becomes Law. California Office of Senate Reprographics. March, 2001.

Cohen D. "What is 'Advocacy?" *Volume 1: Reflections on Advocacy*. Advocacy Institute, 2001.

Consumers Union. "Legislative Advocacy Glossary." February, 2002.

Goldwater B. Early Stirrings: The Forgotten American. *Conscience of a Majority*. Prentice-Hall: Englewood Cliffs, N.J.. 1970, pp. 9-23.

Holton R. Reflections on Public Policy Grant Making. *Reflections*. The California Wellness Foundation: 2002, pp. 2-4, 11-17.

Jacobs J. The Legislator. *A Rage for Justice*. University of California Press: 1995, pp. 198-216.

Kessler D. Opening Battles. Chapters 8 and 10. *A Question of Intent*. Public Affairs: New York, 2001, pp. 54-59 and 67-71.

Lewin NL, Vernick JS, Beilenson PL, Mair JS, Lindamood MM, Teret SP, et al. The Baltimore Youth Ammunition Initiative: A Model Application of Local Public Health Authority in Preventing Gun Violence. *Am J Pub Health* 2005, 95(5):762-765.

Matthews C. Don't Get Mad; Don't Get Even; Get Ahead. *Hardball: How Politics is Played, Told By One Who Knows the Game.* Simon & Schuster: New York. 1999, pp. 105-115.

Mebane F and Blendon R. Political Strategy 101: How to Make Health Policy and Influence Political People. *Journal of Child Neurology*, 16:513-19. 2001.

Powell LF. Attack on American Free Enterprise System. The Powell Memorandum. U.S. Chamber of Commerce, 1971.

Teret SP. Litigating for the public's health. *AJPH* 1986; 76:1027-9.

Vernick JS, Mair, JS, Teret SP, Sapsin JW. Role of litigation in preventing product-related injuries. *Epidemiologic Reviews* 2003; 25:90-98.

Vernick JS, Teret SP, Webster DW. Regulating firearm advertisements that promise home protection: A public health intervention. *JAMA* 1997; 277(17):1391-1397.
AJPH 1986; 76:1027-9.

How a Bill Becomes a Law — The Real Version. Other Views. *Sacramento Bee*. October 2, 2001.

other resources

Alliance for Justice
http://afj.org/

California Health Interview Survey
http://www.chis.ucla.edu/

Consumer Watchdog
http://www.consumerwatchdog.org/

First Amendment Coalition (for accessing public records)
http://www.cfac.org/content/index.php/cfac-records/index/

Freedom of Information Act (FOIA)
http://www.usdoj.gov/oip/

Urban Institute's Health Policy Center
http://www.urban.org/content/PolicyCenters/HealthPolicy/Overview.htm

government sources

Bureau of Primary Health Care, U.S. Department of Health and Human Services
http://www.bphc.hrsa.gov
Government information regarding health care policies, including resources, databases, and documents.

California Health and Human Services, Office of the Secretary
http://www.chhs.ca.gov/
Official site of the California Department of Health and Human Services, information on state and federal programs for health care, social services, public assistance, and more.

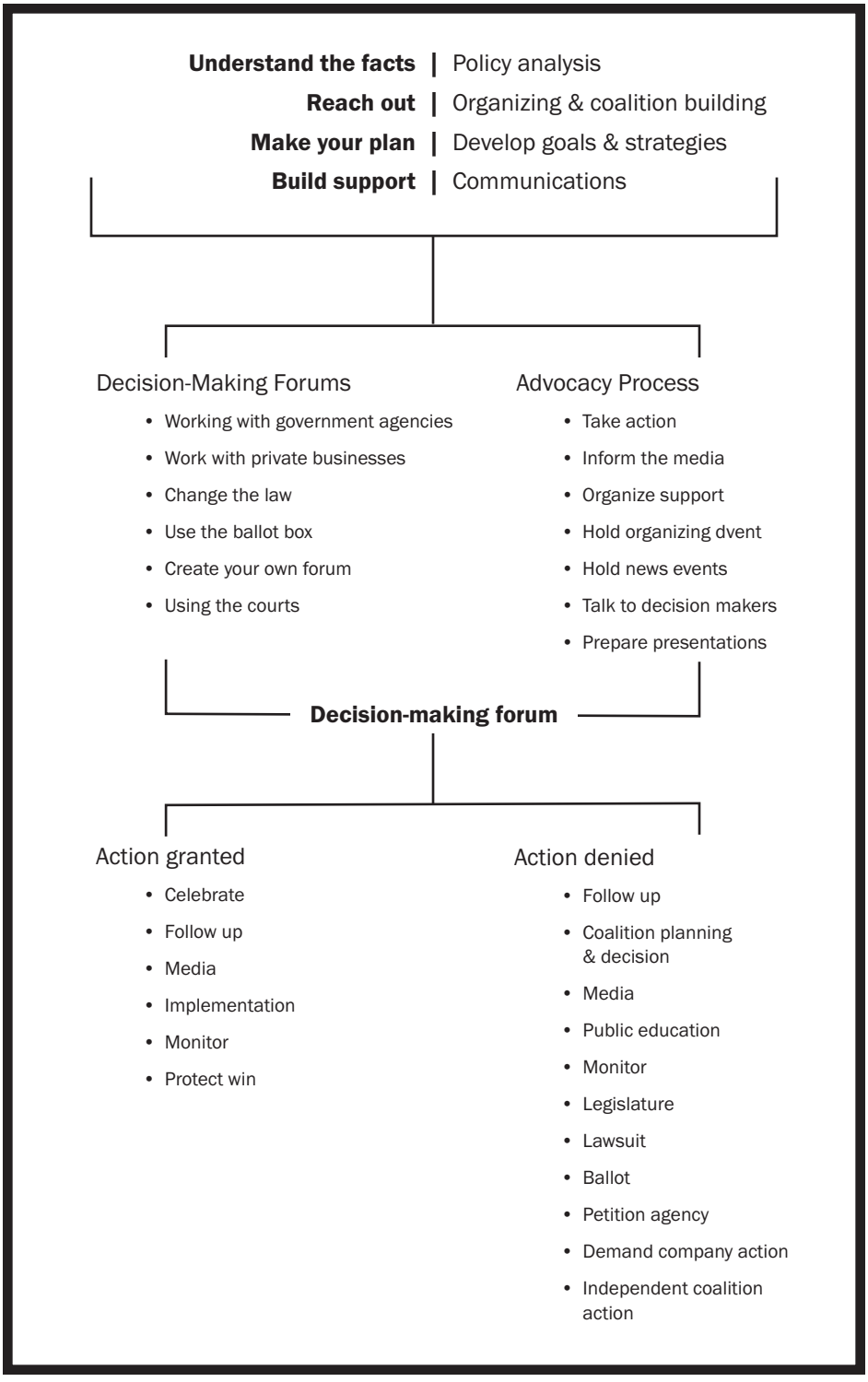
Council on Private Sector Initiatives (CPSI) to Improve the Security, Safety, and Quality of Health Care: Agency Representatives and Contacts, U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality
http://www.cpsi.ahrq.gov/contacts.htm
List of government representatives and contacts useful for advocacy work.

Legislative and Governmental Affairs, California Department of Health Services
http://www.dhs.ca.gov/lga/index.htm
Government information and resources to facilitate, coordinate, and advocate for legislation in the interest of public health.

Office of the Patient Advocate, Department of Managed Health Care, State of California
http://www.opa.ca.gov/
Information to assist health care consumers. Includes policy briefs, reports, and educational sources.

Statutes and Regulations Relating to Health Care Plans in California, Department of Managed Health Care
http://www.hmohelp.ca.gov/library/regulations
Information on Codes, Legislation, and Acts regarding the regulation of health plans in California.

Working for Better Health:
The Health Advocacy Process



administrative petition worksheet

What is one issue or problem that you see again and again that affects many people?

What evidence do you have that this is a problem (e.g., documentation, studies, reports, surveys, interviews, etc.)?

What rule or policy needs to change in order to fix this problem?

Identify the agency or institution that can change the rule or policy.

What gives the agency the authority to make or change such a rule?

What should the agency or institution do?

Who is being hurt by the current situation?

Why does it matter?

What persons or groups are likely to be interested in supporting your petition?

What are the arguments against the rule or policy change?

Why are these arguments wrong?

Type in name of responding agency

_____

_____	)	**ADMINISTRATIVE PETITION**
_____,	)	**TO** (*insert descriptive title)*
(*type in name of petitioner)*	)	_____
Petitioners.	)	_____
_____	)	_____

INTRODUCTION

Petitioners, *(insert name of petitioners*)_____
_____, request that (*insert name of petitioned agency*)_____
_____ take immediate and effective action to (*briefly describe the purpose of the petition*)
_____
_____
_____
_____.

Presently, (*summarize current state of affairs*)_____
_____
_____
_____
_____.

These actions are hurting (*briefly describe who is being hurt by the current state of affairs and how*)
_____
_____
_____
_____.

The (*insert name of petitioned agency)* _____ is under a legal duty to (*briefly summarize the agency's responsibility)* _____
_____
_____
_____.

Petitioners request that the agency fulfill this responsibility by taking the following actions: (*list corrective actions)*
1)_____
2)_____
3)_____

STATEMENT OF FACTS

(*Explain the situation in greater detail – additional pages can be attached if necessary)* _____
_____
_____
_____
_____
_____
_____.

PETITIONERS

(*insert name of petitioner)*_____
_____,
is a non-profit organization that is dedicated to (*describe the purpose of the organization)*_____
_____.

To this end, (*Petitioner's name)* _____*,* is active in (*describe the organizations activities)*_____
_____.

(OR)

*(insert name of petitioner)*_____ is a citizen of the state of _____. She is directly affected by the current state of affairs because (*describe how the petitioner is affected)*_____
_____
_____.

AUTHORITY

The right to petition state agencies is contained in (*insert the code section number of state petitioning law, e.g. California Government Code Section 11340.7)*_____,
Which provides that any interested person may petition a state agency requesting the adoption, amendment, or repeal of a rule or regulation.

The agency's authority to take the actions requested in this petition derives from (*insert the statute, court decision, or other appropriate legal authority)*_____
_____,
which gives the agency the power to *(quote or summarize relevant portions of the statute or decision)*_____
_____
_____
_____.

(*insert additional authority if any)*_____ further provides that the agency (shall or may) (*quote relevant portions of the statue or decision)*_____
_____.

RELIEF REQUESTED

Petitioners request that the (*insert agency's name)*_____ take the following actions (*list corrective actions requested)*
1)_____
2)_____
3)_____

CONCLUSION

In view of the seriousness of the preset problem, petitioners urge that the (*insert the agency's name)*_____
_____ immediately take the actions set forth in this petition.

DATED: (*insert date of filing)*_____.

Respectfully submitted,
(*insert petitioner's name, if an individual, or petitioner's representative, if an organization)*_____
By: *(Signature)*_____

_____

_____	)	ADMINISTRATIVE PETITION
_____,	)	TO _____
	)	_____
	)	_____
	)	
	)	
Petitioners.	)	
_____	)	

INTRODUCTION

Petitioners, _____

_____, request that the _____

_____ take immediate and effective action to

_____

_____.

Presently, _____

_____

_____ .

These actions are hurting _____

_____

_____

_____ .

The _____ is under legal duty to

_____

_____ .

Petitioners request that the agency fulfill this responsibility by taking the following actions:

1) _____
2) _____
3) _____

STATEMENT OF FACTS

_____

_____

_____

_____

PETITIONERS

_____, is a nonprofit organization that is dedicated to _____ .

To this end, _____ is active in _____

_____ .

(OR) _____ is a citizen of the state of _____ .

She is directly affected by the current state of affairs because _____

_____ .

AUTHORITY

The right to petition state agencies is contained in California Government Code §§ 11340.6, 11340.7 (rulemaking) and in the California Constitution – Art. II, § 24 (general), which provides that any interested person may petition a state agency requesting the adoption, amendment, or repeal of a rule or regulation.

The agency's authority to take the actions requested in this petition derives from _____

_____, which gives the agency the power to _____ .

_____ further provides that the agency (shall or may)

_____ .

RELIEF REQUESTED

Petitioners request that the _____ take the following actions:

1) _____
2) _____
3) _____

CONCLUSION

In view of the seriousness of the present problem, petitioners urge that the _____

_____ immediately take the actions set forth in this petition.

DATED: _____ .

Respectfully submitted,

_____

_____

By: _____

Petitioner

worksheets: understanding how to impact health policy

The worksheets outline tasks that will help to organize your research, writing, decision-making and actions. Your answers will provide a convenient summary of your findings and strategy, and form the basis for your plan.

Getting the facts: researching the problem

1 The following persons are being hurt by the current situation:

a.

because

b.

because

c.

because

2 The persons listed in No.1 are able/unable to protect themselves because:

3 This is a serious problem because:

4 The following persons and organizations are benefiting from the current situation:

a.

because

b.

because

c.

because

5 How wide-spread is the problem?

6 If left unattended, the problem is likely to (get worse/stay the same/get better) because:

7 What has been done elsewhere to solve the problem?

8 What could be done to solve the problem?

Research findings

Note: Using credible sources (including information from community organizations as well as individuals, books, the Internet, government documents, databases and academic sources) is essential when getting the facts. Proper referencing is also important to build the case for why action should be taken.

Key facts about the problem:

a.

reference source

b.

reference source

c.

reference source

d.

reference source

e.

reference source

Building support: inviting others to join

1 The following persons/groups are likely to be interested in supporting your advocacy efforts:

a.

because

b.

because

c.

because

d.

because

e.

because

2 The person(s) who will be responsible for contacting the above persons/groups and asking for their support is:

Name	Date will contact by
a.	**a.**
b.	**b.**
c.	**c.**
d.	**d.**
e.	**e.**

3 What do people/groups think about the problem as you describe it:

a.

because

b.

because

c.

because

d.

because

e.

because

4 What do they think should be done:

a.

b.

c.

d.

e.

5 Will they join in your efforts:

a.

b.

c.

d.

e.

Making a Plan: Developing Solutions

1 What is the issue/problem:

2 What do you want changed?

3 Who can fix it?

4 What are possible solutions?
The decision makers could solve or alleviate the problem by:

a. prohibiting persons from:

1.

2.

3.

4.

b. permitting persons to:

1.

2.

3.

4.

c. requiring persons to:

1.

2.

3.

4.

d. taking disciplinary action against:

1.

2.

3.

4.

e. holding hearings on or open an investigation on:

1.

2.

3.

4.

f. performing the following services:

1.

2.

3.

4.

g. also taking the following actions:

1.

2.

3.

4.

h. What are your three most preferred solutions:

1.

2.

3.

5 Who else agrees with you or supports you?

6 Who opposes you?

7 What is the plan? Clearly state:

a. Interim goals to achieve your policy solution

b. Tasks and timeline to accomplish interim goals

c. Partners you will work with in coalition

d. Available resources, including:
1. funds

2. personnel

3. office space and support

e. How your plan will build the capacity of the community to advocate for policy change.

8 Which place(s) where decisions are made (government agencies, legislature, ballot box, business and other organizations and courts) will you use to achieve your policy goal?

9 What is the role of direct group action in your plan?

Communicating your message: getting the word out

1 Reaching your audience

a. You need to reach the following persons because they are affected by the problem and need to be aware of the issues and what can be done:

1.

2.

3.

4.

5.

6.

7.

b. You also need to reach the following persons because they are likely to be influential in persuading decision makers:

1.

2.

3.

4.

5.

c. Who are the decision makers who need to take the action you want:

1.

2.

3.

4.

2 In this case, a broadly accepted value that will persuade this audience to take the action you recommend is:

3 What facts should be emphasized to your audience?

4 What is a simple and compelling story that can describe your broadly accepted value(s) and the facts you have identified?

How to Reach Your Audience

1 The media which will reach your audience are:

a. Newspapers (daily, weekly, student, foreign language, neighborhood, etc.):

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

b. Radio station (network, local, foreign language, university, public, etc.):

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

c. Television stations (network, local, cable, foreign language, public, etc.):

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

d. Magazines (weekly, monthly, specialty):

1.

2.

3.

4.

5.

6.

7.

8.

e. Wire services:

1.

2.

3.

4.

5.

f. Other:

1.Community organizations and church newsletters

2.

3.

4 Number the previous media outlets in order of importance/effectiveness in reaching your audience.

a.

b.

c.

d.

e.

f.

g.

h.

i.

j.

5 Your media contact person will be:

6 The theme(s) you will emphasize to the media is (are):

a.

b.

c.

7 To explain the issue to reporters you will use (check one or more):

_____ News release

_____ News conference

_____ Other _____

8 You will issue your news release/hold your news conference

on _____

at _____

Note:

The information collected on your worksheet is the basis of your news release or press conference. Keep the worksheet before you as you plan. Periodically, review the worksheet to insure that you have not forgotten anything.

After you take action

1 The person who is responsible for keeping in touch with individuals in the place *where decisions are made*:

2 You will also monitor the decision maker's action by:

3 The person who is responsible for keeping your coalition and supporters up to date on the progress of your action is:

4 The person who is responsible for keeping the media up to date is:

If your issue is scheduled for a meeting or a hearing:
find out what format the meeting or hearing will take

1 The arrangements are (satisfactory/unsatisfactory) because:

2 If the arrangements are unsatisfactory, the actions you should take are:

a.

b.

c.

d.

Prepare for your meeting or hearing

1 In preparing your presentation you should:

a. Bolster the following points

1.

2.

3.

4.

5.

6.

b. Present the following changes in the facts, law, or government policy since your last public statements:

1.

2.

3.

4.

5.

6.

c. Respond to opposing arguments as follows:

Opposing argument:	Your response:
Opposing argument:	Your response:
Opposing argument:	Your response:

Note: The information collected on your worksheet is the basis of your presentation.

2 At the presentation, advocates on your side will be:

Advocates:

Presenting on:

3 Your media contact person will be:

4 The person responsible for taking notes and obtaining copies of the meeting or hearing testimony is:

Marshall support

1 You will ask the following persons/groups to support your effort by testifying or attending the meeting or hearing by sending a letter of support:

a.

b.

c.

d.

e.

f.

g.

h.

i.

2 The person(s) responsible for contacting the above persons/groups is (are):

Post meeting or hearing comments

1 The arguments raised in opposition are:

a.

b.

c.

d.

2 They are defective because:

a.

b.

c.

d.

3 Recent developments adding to your case are:

a.

b.

c.

d.

4 Items you promised to supply the decision maker are:

a.

b.

c.

d.

If your solution is adopted

1 Before the decision becomes effective (list actions which must occur before the decision is effective):

a.

b.

c.

d.

2 You will issue a news release/hold a news conference

on _____

at _____ am/pm

3 This decision will solve/alleviate the original problem by:

4 To solve the entire problem, you should:

5 You will express appreciation by:

If your solution is denied

1 You should/should not try again in your chosen place *where decisions are made* because:

2 You should/should not go to the legislature for a bill, resolution, or hearings because:

3 You should/should not try to work with or petition a government agency because:

4 You should/should not try to work with businesses or other organizations because:

5 You should/should not try to get an initiative on the ballot because:

6 You should/should not pursue a court action because:

7 You should/should not try to take direct group action because:

6

Community Organizing

introduction

Community organizing is a dynamic process that encompasses a wide range of community engagement strategies, including people defining their own community, identifying common issues they wish to address, defining the solutions they wish to pursue and the methods they will use to mobilize resources, and implementing strategies for reaching the goals they have collectively set. A critical dimension of community organizing is a power analysis of social change, rooted in political economy and concerned with dynamics of oppression and privilege.

This lesson presents community organizing as a public health strategy connected to social action. It identifies principles of operation as well as basic techniques for implementation, including practical strategies for outreach and recruitment, involving stakeholders, and other forms of civic engagement.

Community organizing requires a human rights framework. This is necessary because collaborative work can be used to promote agendas that are not conducive to health, as in the case of anti-immigrant organizing, denial of civil rights on the basis of sexual orientation, or efforts to limit women's reproductive rights. Many Americans may think that human-rights violations only happen in other countries; however, in the United States one in five young people live in poverty, often without the basic needs of health care and housing. Health disparities are a violation

of human rights recognized under international law. People have the right to organize and come together to address a range of health and social problems, including chronic illness, skyrocketing medical costs, and the ever-expanding gap between rich and poor. By joining the larger human rights movement, public health professionals can connect and confront injustice at the global level while leading their own communities toward local solutions.

An important outcome of applying community organizing strategies, often mandated by both public and private health-funding agencies, is community participation and coalition building. Public health professionals assist in the process of developing community partnerships. To this end, it is vital that practitioners develop effective interpersonal and cross-cultural communication skills. Racism and privilege, in particular, are important to identify and discuss not because they are more important than other social dimensions, such as class, sexual orientation, age or gender, but because of the particular history of the U.S., and how these same issues arise frequently in practice. The value of cultural humility and need for collaborative leadership are critical to address in order for public health practitioners to develop mutually beneficial, non-paternalistic partnerships with communities.

One of the hallmarks of community organizing is recognizing the need for interdependence. Thus, this lesson reflects experiential learning and transformative pedagogy that organizes the classroom into a learning community. This lesson focuses on solutions, strengths, and assets that build a "community identity," as opposed to the traditional reductionist focus on problems. The process demonstrates the effects of an asset-building approach that has proven successful in community settings.

learning objectives

The purpose of this lesson is to provide students with an understanding of how community organizing can be used as part of an advocacy strategy to promote healthy public policy. The overarching goals are to prepare students to work in culturally diverse communities, increase listening skills, build relationships of mutual trust, and facilitate and collaborate in social change. Students will learn methods for engaging communities in assessing and taking action on public health issues.

By the end of this lesson and completion of all assignments, students will be able to:

1. Articulate the history of community organizing to include community-level health inequities as a violation of human rights and our country's tradition of nonviolent social action
2. Identify principles of community organizing, including listening, cultural humility, relationship building, issue selection, reflection, evaluation, and celebration, as well as basic techniques for implementation focusing on strengths and assets
3. Describe practices of civic engagement
4. Describe the value of actively engaging communities in assessing public health problems and advancing policy solutions
5. Describe a range of community assessment methods, including participant observation, community mapping, key informant interviews, and basic principles of community-based participatory research
6. Critically assess the ethical dilemmas that can arise in organizing communities and building coalitions between public health professionals, community members, and other health advocates

key points to be made in lesson

1 Three goals of this lesson

We define three goals for this lesson: 1. To deepen understanding of community organizing to include community-level health inequities as a violation of human rights; 2. To acknowledge our country's tradition of nonviolent social action; and 3. To identify principles of community organizing, as well as basic techniques for implementation that focus on community-based strengths and assets.

Goals of this module

- History, principles and practices of community organizing & community based participatory research
- Health inequities a violation of human rights & legacy of non-violent social action
- Essential qualities: cultural humility & empowerment

2 What do we mean by *community*?

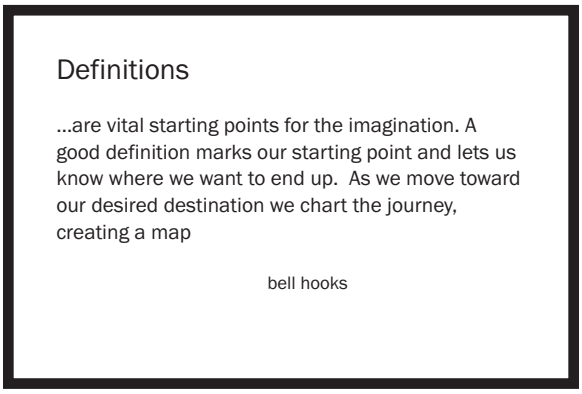
The World Health Organization defines community as a group of people, often living in a defined geographical area, who share a common culture, values, and norms. While typically thought of in geographical terms, communities may also be based on shared interests or characteristics, such as race or ethnicity, language, sexual orientation, age, or occupation.

What is community?

- Individual vs. Community
- Interdependence
- *A group of people, often living in a defined geographical area, who share a common culture, values, and norms.* [World Health Organization]
- Shared interests or characteristics: race/ethnicity, language, sexual orientation, age, or occupation.

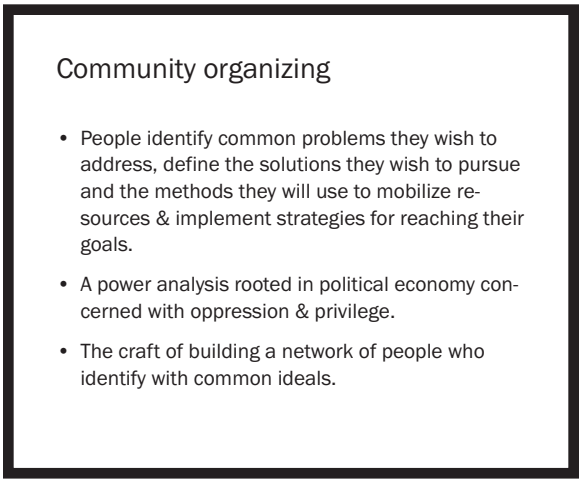
3 Individuals and communities

"Definitions," observes bell hooks, "are vital starting points for the imagination. A good definition marks our starting point and lets us know where we want to end up. As we move toward our desired destination we chart the journey, creating a map." Our first task, then, is to define "community." Scott Peck defines community as "a group that has learned to transcend its individual differences." Contrary to the dominant narrative of rugged individualism that permeates much of American life, Peck recognizes that people also strive for community and interdependence. The tension between individualism and community is central to understanding social tensions in the United States. On the one hand, people need to be recognized as individuals; on the other hand, they depend on others for collective well-being. The dominant cultural narrative in the U.S. reinforces the idea that individuals are largely responsible for their own health; that is, each of us has the personal responsibility to avoid getting sick or injured, and when we do, to get well on our own. Yet at the same time, people are social beings operating in a web of interrelatedness. Ultimately, our health depends not only on what we do as individuals, but also on our connections with people (e.g., our friends and families), as well as institutions, environments, and communities.



4 Community organizing

In its best practice, community organizing is a long-term approach in which people define their community, common problems or goals they wish to address, their desired solutions, the methods they will use to mobilize resources, and strategies for reaching the goals they have collectively set.



5 Historical context

The term *community organizing* was first used by American social workers in the late 1800s to describe their efforts to coordinate health and social services for European immigrants and the poor through the settlement house movement. Important milestones outside of social work include the post-Reconstruction period organizing by African Americans fighting white supremacy and Jim Crow segregation laws in the last two decades of the nineteenth century; the Populist movement that started in the late nineteenth century among farmers and became a multisectoral coalition and a national political force; non-violence social action organizing from the labor movement; the women's movement; and the more recent organizing for disability and gay rights.

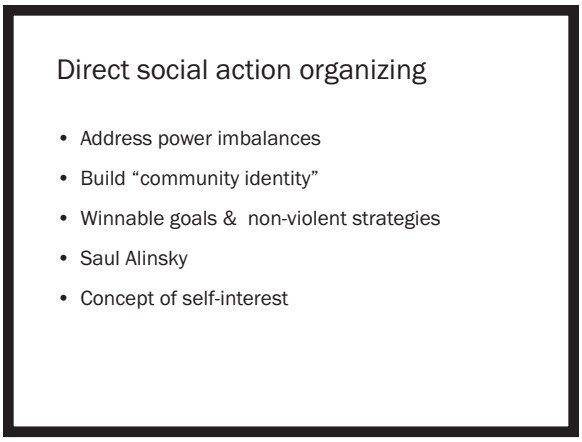
6–7

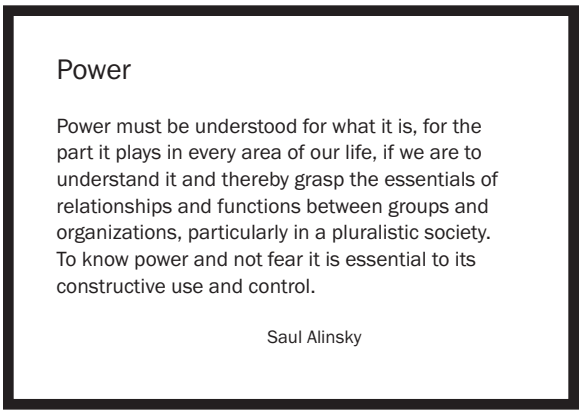
Direct social action organizing

Direct social action organizing was championed in Chicago by Saul Alinsky in the 1940s. Alinsky used confrontation strategies, such as organizing strikes that led to better health and work conditions for factory workers. Direct social action organizing emphasizes redressing power imbalances, building a community identity, and helping members devise winnable goals and nonviolent conflict strategies as means to bring about change.

In addition, Alinsky noted that community organizing will fail if it does not recognize people's self-interest. When self-interest is aligned with organizational interest or public interest, organizations and campaigns are more sustainable.

Alinsky also redefined the concept of power. Alinsky's message to ordinary people was that the wealthy already asserted their power, and were not afraid to do so. If the average person ever wanted to take control of his own life, he would have to learn to use power as well.





8 Nonviolent social action

Nonviolent social action is a framework for understanding power and conflict that challenges cultural assumptions and beliefs in force, domination, and power as the way to win. The theory and practice of non-violence is a paradigm shift that was used throughout the civil rights movement in the 1960s, the anti-war movement in the 1970s, and the anti-apartheid struggle in South Africa in the 1980s. This organizing model traveled to California, where César Chávez and Dolores Huerta combined direct social action organizing, Mahatma Gandhi's nonviolent message of non-cooperation with oppression, and their profound commitment to agricultural workers, in order to develop a network of organizations and found the United Farm Workers union. Organizers in communities of color brought a new level of analytical sophistication, emphasizing issues of race, class, and gender, and developing indigenous leadership. Today's anti-war, environmental justice, and immigrant rights movements also use nonviolent methods such as boycotts, fasting, protests, songs and popular theater, and civil disobedience (the active refusal to obey certain government laws).

Non-violent social action

- A paradigm shift: civil rights movement, anti-war movement, anti-apartheid struggle
- A framework that challenges cultural beliefs in force, domination and power over
- Cesar Chávez, United Farm Workers

9 The personal is political

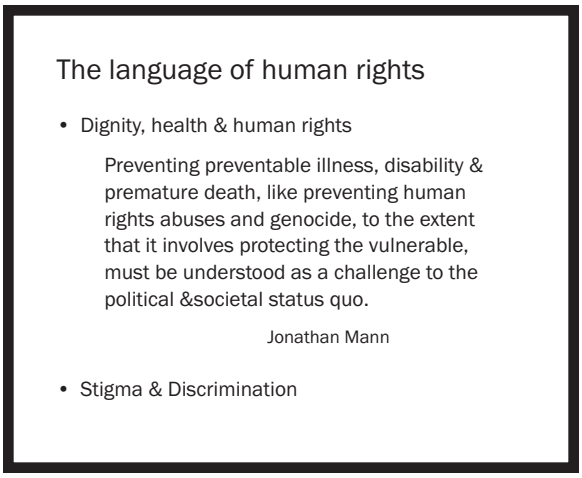
The women's health movement of the late 1960s and 1970s added an important dimension of personal experience to nonviolent social action that challenged medical authority in many aspects of women's health, health access, and health care delivery. Movement participants developed self-help manuals such as *Our Bodies, Ourselves* and founded birth centers run by midwives. Women-centered community organizing has a long history, which some trace back to African American women's efforts to sustain home and community under slavery.

The personal is political

- The women's health movement
- *Our Bodies, Ourselves*
- Consciousness raising & legislation on reproductive rights, body awareness, sexual and domestic violence
- Change of norms in relationships, sexuality, work, and family.

10 The language of human rights

Community organizing is concerned with institutional and interpersonal dynamics of power and privilege. This addresses violations of human rights such as racism, class oppression, gender inequality, sexual discrimination, and other community-level health inequities. Jonathan Mann, a leader of a worldwide movement to recognize and promote the inter-relationship between health and human rights, said, "Preventing preventable illness, disability, and premature death, like preventing human rights abuses and genocide, to the extent that it involves protecting the vulnerable, must be understood as a challenge to the political and societal status quo." His legacy is to raise consciousness in public health around stigma and discrimination as human rights violations.

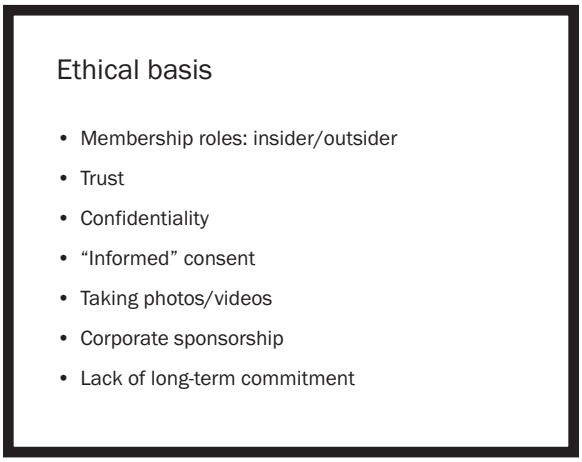


11–12
Empowerment

An important characteristic of community organizing is leadership development. Empowerment is a process by which people, organizations, and communities gain mastery over the issues that are important to them. It includes the development of self-confidence, a critical worldview, and the cultivation of individual and collective skills and resources for social and political action. While empowerment may include the dimension of transferring power to others, the organizer cannot directly empower the community; empowerment is something people do for themselves.

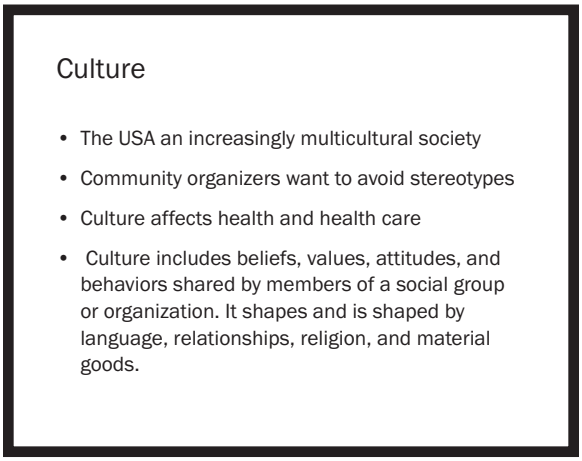
13 Ethical basis

It makes a difference when community organizers are health experts coming from outside the community, as opposed to members organizing from within the community. The question of whether a health professional can organize across race, class, gender, and/or other categories is important to address. Ethical issues such as being community *insiders* or *outsiders,* who is included and who is excluded, confidentiality, "informed" consent, taking photos/videos of community members, corporate sponsorship, and lack of long-term commitment by health professionals and institutions, are all important for practitioners to consider. Given historical abuses of power, such as the Centers for Disease Control's Tuskegee study of syphilis that created distrust of researchers among the African-American community, it makes sense that "outside/expert" organizers raise suspicion. Thus, in 2002 the Public Health Leadership Society developed *Principles of Ethical Practice*, to provide public health institutions and practitioners an ethical standard to which they can be held accountable.



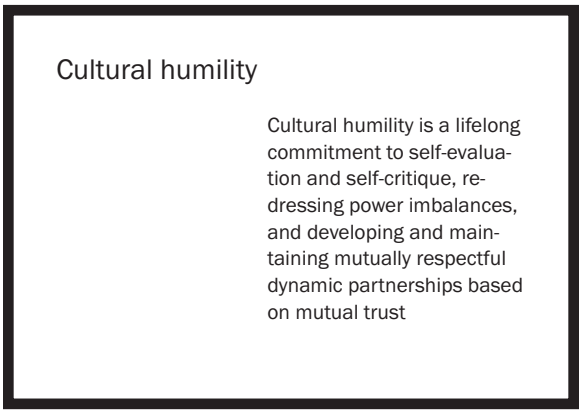
14 Culture

Culture includes beliefs, values, attitudes, and behaviors shared by members of a social group or organization. It shapes and is shaped by language, relationships, religion, and material goods. Our perceptions are informed by the cultures we are born into, grow up around, and are socialized by. Culture affects health and health care by encouraging certain health behaviors and discouraging others, providing definitions for personal experience and prescribing idioms of distress, and providing a social context. Cultural variations across communities are numerous and complex, even within the same ethnic group. To avoid misleading reductionism or stereotypes, effective community organizers must recognize that it is not possible to predict the beliefs and behaviors of individuals based on their race, ethnicity, or national origin.



15 Cultural humility

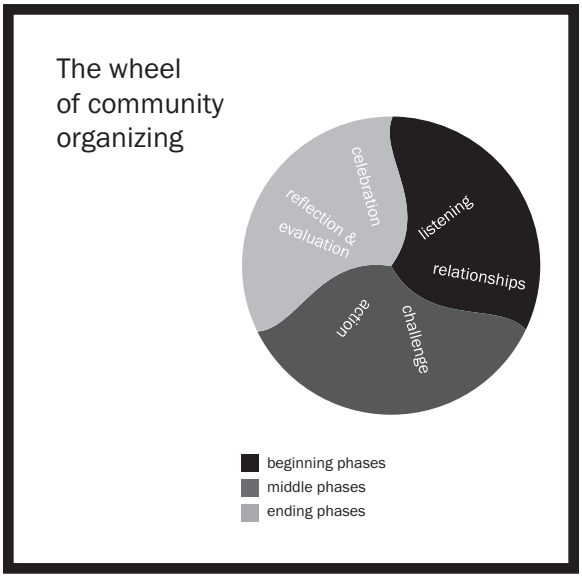
The civil rights movement began a process whereby historically oppressed groups highlighted their cultural differences and asserted cultural pride. "Black Power," "Gay Pride," "Girl Power," and other popular phrases affirm the capacity for change within oppressed communities. Nonetheless, a necessary element of community organizing, particularly when the organizer is an outsider, is cultural humility. Cultural humility is a lifelong commitment to self-evaluation and self-critique, redressing power imbalances, and developing and maintaining mutually respectful, dynamic partnerships based on shared trust. In this model, the most serious barrier to culturally appropriate care is not a lack of knowledge of the details of any given cultural orientation, but the failure to develop self-awareness and a respectful attitude toward diverse points of view and ways of living.



16 The wheel of community organizing

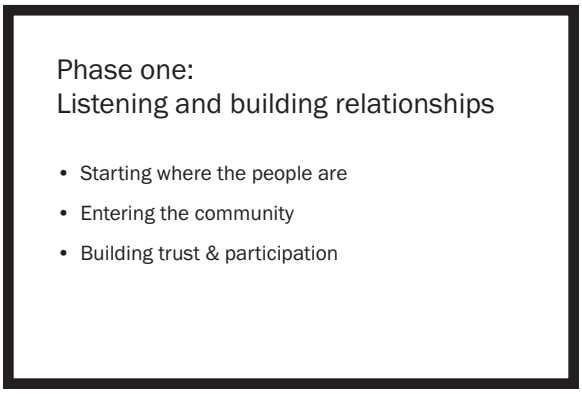
The "wheel of community organizing" offers a set of cyclical principles that an organizer can use in three phases to support his/her work. The model is based on seven principles: listening, relationships, challenge, action, reflection, evaluation, and celebration, and it is structured in beginning, middle, and ending phases. These principles are cyclical in that they are repeated, each time building on assessments of earlier successes, errors, and lessons learned. The three phases are logically linked with each other, and to the cycle as a whole. All principles are needed; the absence of any one will weaken the overall impact.

The wheel of community organizing takes organizers through the practical steps of issue selection, goal and strategy development, identifying targets and tactics, building capacity and leadership, taking action, and finally, reflection and evaluation.



17 Phase one: Listening and building relationships

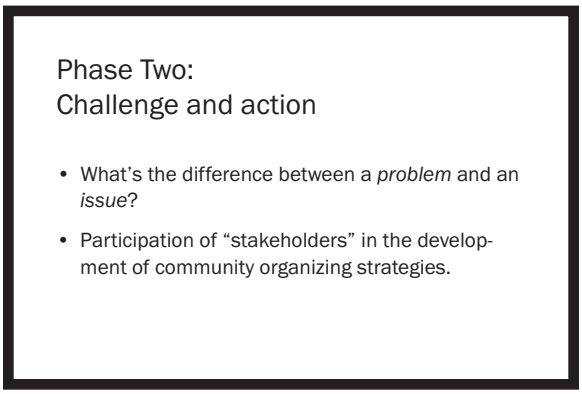
We are trained in a culture that values personal expression and speech over listening. Further, we are socialized as public health professionals with expert roles that may conflict with building community and developing relationships. *Listening*, or "starting where the people are," enables the organizer to become familiar with the community, its history, its demographics, its geography, and its political leadership. *Entering a community* requires learning community norms, as well as developing personal relationships. This phase is basic to *building trust and promoting community involvement*. It includes asking questions, participating in formal community events, and engaging in many casual activities to demonstrate respect and cultural humility.



18 Phase two: Challenge and action

Once the group has identified its goals, the organizer's responsibility is to keep the momentum of the group moving forward. One of the most important steps in community organizing involves the effective differentiation between *problems*, or things that are troubling, and *issues* the community feels strongly about. A health *issue* must be simple and specific so that any member of the group can explain it clearly in a sentence or two. A health *issue* must unite members of the group and involve them in a meaningful way in achieving resolution. An *issue* is part of a larger plan or strategy that builds community capacity.

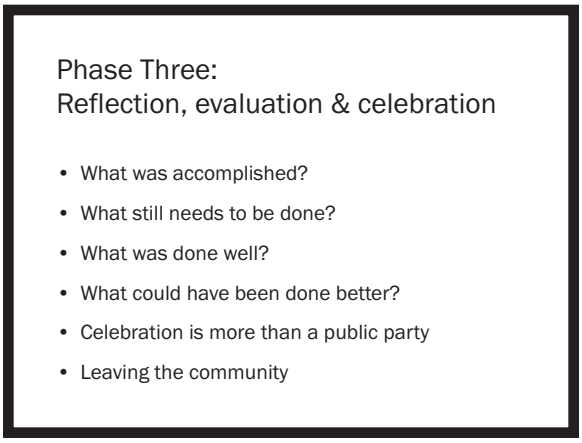
For example, the *problem* of childhood obesity is a personal and political health challenge that may seem insurmountable. But the *issue* of vending machines in public schools selling sugar-filled sodas, candy-bars, cakes and other processed foods is one on which community organizers can take action. A key to turning problems into issues is the participation of stakeholders in the development of community organizing strategies (see Lessons 4 and 6 for more on stakeholders).



19 Phase three: Reflection, evaluation, and celebration

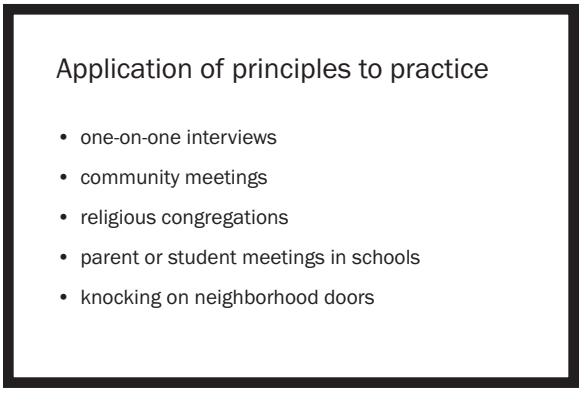
After the action is taken, the next phase requires that community organizers carefully review progress, ensure that it is on track, and evaluate their own efforts, limitations, and contributions. The goal is to understand what went right or wrong for the benefit of future efforts. Reflective questions include: What was accomplished? What still needs to be done? What was done well? What could have been done better?

Lastly, every community organizing process ideally concludes with celebration. Celebration is a ceremony of completion that confirms the legitimacy and appropriateness of community participation and empowerment for social justice. When community members are publicly recognized for successfully engaging in local action, it revitalizes their commitment. This last phase is an opportunity to start another mobilization cycle.



20 Application of principles to community organizing practice

Community members must be invited to join the cause. The practical ways in which organizers issue invitations to engage community members vary based on the issue and the setting. [*Instructor: ask the class to generate ideas for how a community organizer might invite new members into the effort.*] Organizers practical methods can include one-on-one interviews, attending community meetings or meetings of religious congregations, making presentations to parent or student meetings in schools, and knocking on neighborhood doors.

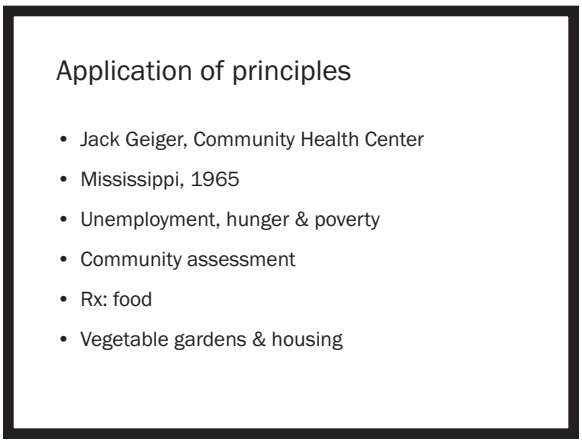


21 Application of principles of community organizing: Jack Geiger example

In 1965, Dr. Jack Geiger and his colleagues opened one of the first community health centers in the U.S. in Mississippi. At this time, the invention of the double-row cotton-picking machine had recently replaced the need for an entire population of sharecroppers, causing unemployment, hunger, and poverty. To assess community needs, the health center began holding a series of meetings in homes, churches, and schools where they listened and built relationships. Community participation played a central role in broadening traditional conceptions of health. Some communities needed clean drinking water, others needed child care or elder care, and most were suffering from malnutrition.

Geiger and his colleagues linked *problems* of hunger to acute poverty, and linked poverty to the massive unemployment that had turned an entire population into squatters. The health *issue* they selected was lack of local food, and doctors wrote prescriptions for that. Health center workers recruited local black-owned grocery stores to fill the prescriptions, and reimbursed the stores out of the health center's pharmacy budget. They organized the community to grow vegetable gardens instead of cotton. Health center workers repaired housing, dug protected wells and sanitary privies, and later even started a bookstore focused on black history and culture.

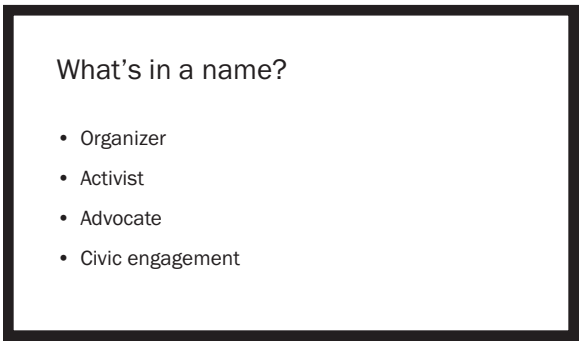
Reflecting on these historical efforts, it is clear that by addressing the roots of illness drawn from community concerns, these health centers pioneered a methodology for approaching health care in underserved communities. Nonetheless, while we celebrate the accomplishments and are inspired by the creativity of Geiger and his colleagues, it is important to note that he and the residents of Mississippi continue with the struggle for health and human rights.



22 Civic engagement: What's in a name?

Although the terms *organizer, activist*, and *advocate* are often used interchangeably, some experts in the field differentiate in describing people working to make a difference in the civic life of the community. *Advocates* tend to be professionals working on behalf of a community that may not be able to represent itself. *Activist* implies militancy, protest, and social movement. An *organizer* describes someone working behind the scenes to support the community voice, or a campaign or program manager, coordinator, or prevention planner.

Civic engagement encompasses a large range of activities, such as volunteering in church, writing a letter to an elected official, working on community issues, participating in the schools, voting, and serving on jury duty. A criticism of the term "civic engagement" is that it is increasingly being used to promote service as a means of helping shore up the safety net sagging under the weight of government cutbacks in health and human services, as opposed to engagement n the political process to redress power imbalances.



23–24

Community-based participatory research

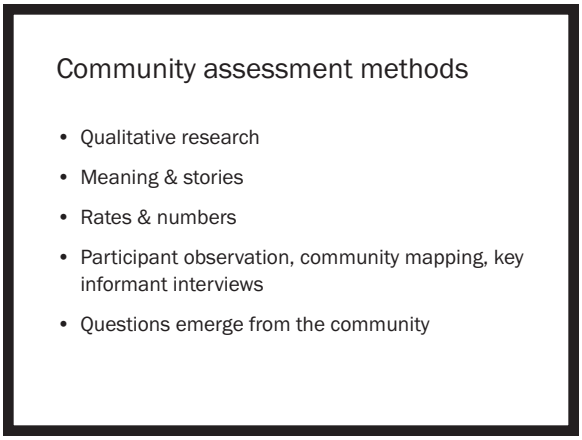
Community-based participatory research (CBPR) is a collaborative approach to research that seeks to equitably involve community members, community-based organizations, government, and academic institutions in the research process, recognizing the unique strengths of each. CBPR aims to combine knowledge with action in order to achieve social change to improve health outcomes and eliminate health disparities. Participatory research challenges practices that separate the researcher from the researched, and promotes the forging of partnerships between researchers and the people under study. This approach redefines the subject of research by having the researcher act more as a resource than the leader. Barbara Israel and colleagues outline the principles that guide this process as follows:

1. Involvement of community, practitioner, and academic partners in all major phases of the research process, including development, implementation, evaluation, dissemination of findings, and subsequent actions of the partnership;

2. Conduct of research that is beneficial, respectful, and useful to the community;
3. Dissemination of findings in ways that are understandable and relevant to community members involved; and
4 Integrating research and action for the benefit of all partners.

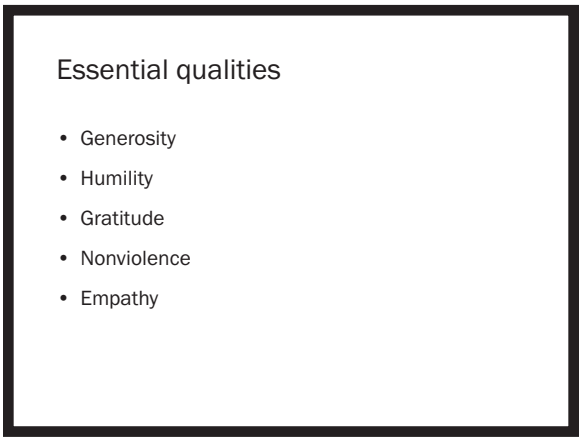
25 Community assessment methods

Community assessment is a technique used in community organizing to assess community needs. Methods include participant observation, community mapping, key informant interviews, and basic principles of community-based participatory research. There has been an explosion of qualitative community assessment methods in public health over the last twenty years. Community assessment is no longer strictly interested in "what," "where," and "when" questions, but now also the "why" and "how" questions. Qualitative methods can be used to answer these questions with focused samples rather than large random samples. Qualitative data typically consist of words and stories, while quantitative data consist of statistics, rates, and numbers. For community organizers this means that the best way to understand what is going on is to become immersed in it. Rather than approaching measurement with the idea of constructing a fixed instrument or set of questions, allow the questions to emerge and change as you become familiar with what you are studying. Participate in the community, and experience what it is like to be a part of it.



26 Essential qualities

As we have seen, there are many functions of community organizing. However, not all of us are well-suited to be organizers. According to Saul Alinsky, community organizers must be able to clearly communicate their values, interests, and motivations. César Chávez noted the following essential qualities of a community organizer.



Generosity:
work hard for others; give credit to everyone else.

Humility:
one's own importance can get in the way of building community.

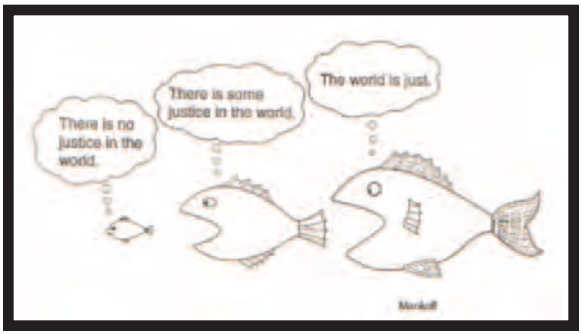
Gratitude:
coming from a place of thankfulness in thoughts and actions.

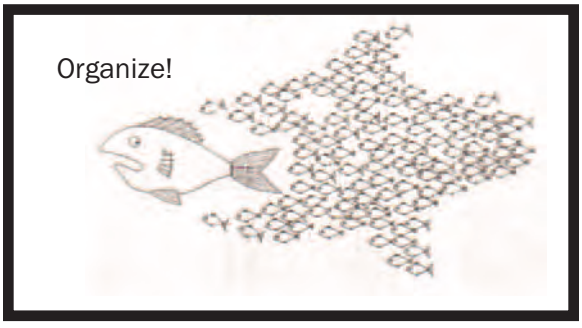
Nonviolence:
be the peace you are seeking from others.

Empathy:
maintain the capacity to connect to others, and see oneself as part of the whole instead of separate.

27–28
Conclusion: Big fish eats the little fish

The current system of power relations in the United States is unjust; health problems are systemic, institutional, and also deeply personal. Community organizers cannot underestimate the importance of perspectives based on power, privilege, and justice. In this cartoon the little fish is feeling oppressed and yelling, "There is NO JUSTICE in this world!" An average-sized fish, perhaps like most of us, is somewhere between feeling threatened and content; this fish says, "There is *some* justice in this world." The big fish in the pond arrogantly defines what is fair and is not fair, claiming, "The world is just." What would it be like if all those little fishes out there by themselves, yelling for their specific issues, joined forces and *organized*? Community organizing is the process that brings people together to fight injustice and develop common solutions for people's health. It is a practice of resistance, self-awareness, building alliances, and "starting where the people are." We are part of this system, and at the same time organize against it.





discussion questions

These discussion questions ask students to consider the cultural contexts of the communities with which they might work. For instance, it is important to understand the culture of queer youth in relationship to the culture of adult health professionals. These questions presume every community has a culture, including the learning community in the classroom. Knowing the strengths and assets of the community, as well as the goals of the organizing process, will lead to more effective results.

A Brainstorm the various communities of identity represented in the classroom. How do you prioritize what communities you belong to?

B Why is it that socially and economically advantaged communities experience better access to health care and better health outcomes despite the fact that our nation agrees, in theory, that no human being is superior to another?

C What essential qualities of community organizing do Saul Alinsky and César Chávez describe? How do your personal leadership skills and attributes compare?

D What is cultural humility? How does it differ from cultural competence? Does this mean that cultural pride is wrong? Can community organizers become competent in a culture outside their own?

E What difference does it make if the community organizer is from *inside* the community or an *outsider* from another community? Can people organize communities across race, class, and gender, or should this work be done with representatives of similar backgrounds? Picture yourself in a community in which you are clearly an *outsider.* What steps will you take to organize the community? How would your action plan be different if you were an *insider?*

skills-building exercise

Community-organizing scenarios

Divide the students into groups of five or six. Ask each group to discuss one of the following scenarios. After a 10-15-minute discussion of important factors to consider, students should present role-plays of solutions to the classroom community.

Scenario #1

As a result of community violence, local seniors live in fear and isolation, and their health status is compromised. A local senior center has asked you to come in to work with a group of senior citizens complaining of violence in the community. Your goal is to address the problem of violence, as well as to increase attendance and participation at the senior center. What steps will you take? How will you enter the community? How will you apply the wheel of community organizing?

Scenario #2

You have been working with a neighborhood community group to address public drunkenness and loitering. Your group has successfully narrowed community alcohol problems into an issue it will bring to the attention of the city council. After your fourth meeting, a community leader stands up and says, "We've been through this before! Twenty years ago we did this whole thing and the city did nothing. The real problem is racism." After the leader's comments, the group becomes demoralized and disempowered. What do you do? What essential qualities of community organizing do you have to put into practice?

Scenario #3

A group of high-school students and a teacher has been working for a year on building community by addressing interracial conflicts on campus, as well as complaints of sexual harassment. Their efforts have paid off: the number of fights has been reduced, and the issue of sexual harassment has been made public and taken seriously. This success attracts local media coverage and gains national attention when *Playboy* magazine offers a donation of $1,000 to plan a large community-building dance, as long as the bunny-ears logo appears on all project materials at the event. The youth are eager to take the money and do not see a conflict of interest. The teacher asks you what to do about the potential corporate sponsorship. How do you respond to this community's request for technical assistance? What ethical dilemmas do you face as a community organizer?

assignments

1 Community profile

This assignment is a short-term ethnographic activity that requires students to systematically get to know a community of their choice, while examining their membership roles as "outsiders" or "insiders." Students informally interview community members and learn the importance of listening and documenting the "authentic voice" of the community through the lens of cultural humility. The goals of this exercise are to explore the complexity of the term "community" and emphasize the importance of local communities' relationships to health. Students decide on the aspects of the community they want to highlight, which may include health concerns, cultural issues (e.g., language, food, norms), political and economic issues, etc. They identify membership roles, health problems, and community resources. Before completing the assignment, students should: 1) describe the community they want to profile, and why; 2) list activities they will observe or in which they will participate; and 3) list two to three people they plan to interview along with the interview questions to ask. The final paper should include direct quotations from community members and integrate concepts from course readings.

2 Community-action project

This assignment requires that students *do something* for the health of a community of their choice. Examples might include participating in a neighborhood clean-up, bringing organic food to be sold at campus eateries, conducting voter registration drives, organizing a campus blood drive, or mobilizing to protest a government action. Students should write a brief, five-page report to be presented to the class, describing the action in which they engaged, how it is related to community organizing, and what they would do differently in future community-based action projects.

possible guest speakers

- Local organizers of various health issues and health care access campaigns
- Coalition convener (e.g., advisory board, task force, community partnership, etc.)
- Staff member from a community-based organization working on community building and/or organizing
- Union organizer
- Members of student organizations

required reading

Cohen L, Chávez V, and Chehimi S. *Prevention Is Primary: Strategies for Community Wellbeing*. Jossey-Bass: San Francisco. 2007.

Minkler M. *Community Organizing and Community Building for Health*. Rutgers University Press: Piscataway, NJ. 2005.

suggested reading

Alinsky S. *Rules for Radicals*. Vintage Books: New York. 1971.

Bobo K, Kendall J, and Max S. *Organizing for Social Change: A Manual for Activists in the 1990s*. Seven Locks Press: Santa Ana, CA. 2001.

Butterfoss F. *Coalitions and Partnerships in Community Health*, Jossey-Bass: San Francisco. 2007.

Chávez V, Duran B, Baker Q E, Avila MM, and Wallerstein N. The dance of race and privilege in community-based participatory research. In M. Minkler and N. Wallerstein (Eds.), *Community-based Participatory Research for Health* (pp. 81–97). Jossey-Bass: San Francisco. 2003.

Ehrlich T. *Civic Engagement, Civic Responsibility, and Higher Education*. Oryx Press: Westport, CT. 2000.

Ferris S, and Sandoval R. *The Fight in the Fields: César Chávez and the Farmworkers Movement*. Harcourt Orlando, FL. 1997.

Fisher R, and Romanofsky P. Introduction. In R. Fisher and P. Romanofsky (Eds.), *Community Organization for Social Change* (pp. xi–xviii). Greenwood Press: Westport, CT. 1981.

Freire P. *Pedagogy of the Oppressed*. Seabury Press: New York. 1970.

Geiger H J. The unsteady march. *Perspectives in Biology and Medicine*, 48:1–9. 2005.

hooks b. *All About Love: New Visions*, Perennial: New York. 2000.

Israel B, Schulz A, Parker E, and Becker A. Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health*, 19:173-202. 1998.

Kahn S. *How People Get Power: Organizing Oppressed Communities for Action*. McGraw-Hill: New York. 1970.

Kretzmann J P, and McKnight J L. *Building Communities From the Inside Out*. Northwestern University, Center for Urban Affairs and Policy Research: Evanston, IL. 1993.

Lao-Tzu. *Tao Te Ching*. A new translation by Gia-Fu Feng and Jane English. Random House: New York, 1972.

Mann, Jonathan M., Gruskin, Sofia, Grodin, Michael A. *Health and Human Rights: A Reader*. Routledge: New York and London, 1999.

McKnight J L. Regenerating community. In J. L. McKnight, *The Careless Society: Community and its Counterfeits* (pp. 161–172). New York: Basic Books. 1995.

Minkler M and Pies C. "Ethical Issues and Practical Dilemmas in Community Organization and Community Participation." In Minkler M. (Ed.), *Community Organizing and Community Building for Health* (pp. 116-132). Rutgers University Press: Piscataway, NJ. 2005.

Nyswander DB. Education for Health: Some Principles and their Application. *Health Education Monographs*, 14: 65-70. 1956.

Peck MS. *The Different Drum: Community Making and Peace*. Simon and Schuster: New York. 1987.

Perez V. The Secret of César Chávez Leadership. *World Hispanic Magazine*, 2004.

Pintado-Vertner R. *The West Coast Story: The Emergence of Youth Organizing in California*. Funders' Collaborative on Youth Organizing: New York. 2004.

Rosenberg MB. *Nonviolent Communication: A Language of Life* (2nd ed.). PuddleDancer Press: Encinitas, CA. 2003.

Rappaport J. Terms of empowerment/exemplars of prevention: toward a theory for community psychology. *American Journal of Community Psychology*, 15: 121-148. 1987.

Shaw R. *The Activists Handbook*. UC Press: Berkeley, CA. 2001.

Stall S, and Stoecker R. Community organizing or organizing community? Gender and the crafts of empowerment. *Gender and Society*, 12: 729–756. 1998.

Tervalon M and Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, 9(2):117-25. 1998.

Wallerstein N, and Bernstein E. (Eds.). Community empowerment, participatory education, and health. *Health Education Quarterly*, 21:141–148. 1994.

Wechsler R, and Schnepp T. *Community Organizing for the Prevention of Problems Related to Alcohol and Other Drugs*. Marin Institute: San Rafael, CA. 1993.

World Health Organization. *Health Promotion Glossary*. Division of Health Promotion, Education and Communications (HPR) Health Education and Health Promotion: Geneva. 1998.

Zimmerman M. Empowerment Theory: Psychological, Organizational and community levels of analysis. In ESJ Rappaport (Ed.) *Handbook of Community Psychology* (pp. 43-63). Kluwer Academic/Plenum Publishers: New York. 2000.

other resources

American Public Health Association: Advocacy reports and code of ethics for public health.
http://www.apha.org/
and Public Health Leadership Society, 2002. *Principles of Ethical Practice Code*.
http://www.apha.org/programs/education/progeduethicalguidelines.htm

The Citizen's Handbook On-line: A quick guide to community organizing. Charles Dobson, 2003.
http://www.vcn.bc.ca/citizens-handbook/

Community Empowerment: Training modules on how to strengthen communities. Philip Bartle, 2005.
http://www.scn.org/cmp

Community Organizing Toolbox: A funder's guide to community organizing.
http://www.nfg.org/cotb/

Corporations and Health Watch: Tracking the effects of corporate practices on public health.
http://www.corporationsandhealth.org/

Developing and Sustaining CBPR Partnerships Curriculum modules.
http://www.cbprcurriculum.info/

General Assembly of the United Nations. Universal Declaration of Human Rights, 1948.
http://www.un.org/Overview/rights.html

Highlander Resource and Education Center, a residential popular education center working with social justice advocates for more than 75 years.
http://www.highlandercenter.org/index.html

Midwest Academy, a leading national training institute on community organizing for social change.
http://www.midwestacademy.com/

7

Coalition Building

introduction

A coalition is a union of people and organizations working to influence outcomes on a specific issue. From the Civil Rights Movement, to women's health organizing, to environmental justice advances, history is full of examples of the power of collaboration. While useful for advocacy, coalitions are a neutral tool and can be used for progressive change or as a means towards any number of positive or negative ends.

Coalitions, one of the most common forms of collaboration, can serve as a forum to share information and resources, to consider a problem from different angles, and to combine forces to resolve it. By bringing together people who may be struggling to achieve the same solution, coalitions minimize reinventing the wheel and can help bring about community and system-wide change that no individual or group could accomplish alone.

This lesson focuses on how to build an effective coalition. It includes strategies for how to: Engage a diverse and effective membership; reward members and build morale; create an effective structure; strengthen and develop interdisciplinary partnerships; and resolve problems, including turf struggles, that may come up during the course of coalition-building.

While coalitions are a common and a logical approach to solving a problem, creating a successful coalition can be much more difficult than it may seem. Coalitions often fail

or flounder given the inherent challenges that come when alliances are made between organizations and individuals. To maximize the effectiveness of coalitions, practitioners and organizations should focus on sharpening their partnership building skills. All coalition members, not only lead agencies, can take leadership roles. The information contained in this lesson will help students understand the purpose of coalitions and how to build and maintain them.

learning objectives

The purpose of this lesson is to provide students with an understanding of how coalition building can be used as part of an advocacy strategy to promote healthy public policy. It will prepare students to facilitate collaborative social change in culturally diverse communities.

By the end of this lesson and completion of all assignments, students will:

1. Understand what coalitions are, their value as well as potential limitations.
2. Be able to identify factors that go into forming and maintaining effective coalitions.
3. Learn strategies for forming and maintaining effective coalitions using eight steps to effective coalition building.
4. Be able to implement strategies to resolve tensions over turf and solve other problems that may arise in their coalitions.

key points to be made in lesson

1-2

When are coalitions most useful?

A coalition is a neutral tool and is useful for many different individuals and groups with different goals. From an advocacy perspective, coalitions can be particularly helpful for disenfranchised communities, which too often have no voice in decisions affecting them. In cases where these communities face the financial and lobbying power of corporations, or address government institutions that maintain a bureaucratic "business as usual" approach of government in ignoring neighborhoods with the least clout, collaboration is essential in securing change. As has been shown through environmental justice organizing, collaborations can bring to light the inequities of environmental health decisions, such as the siting of toxic waste facilities and the placement of factories in neighborhoods where—without organizing—residents would have neither the wealth nor the clout to stop them. In the early days of the HIV/AIDS epidemic, coalitions such as ACT-UP (AIDS Coalition to Unleash Power) effectively lobbied to decrease the cost of medications which quite literally saved and/or extended the lives of many people living with HIV. Coalitions can also be valuable to government agencies. Different departments of government tend to work in 'silos' and have differing backgrounds, beliefs, and objectives. Sometimes this means government agencies can be duplicating efforts or working at cross-purposes. For example, in violence prevention, health education and justice agencies need to work together. Partnerships with community groups can help agencies, especially health and human service organizations, better understand community needs and more effectively meet them. However, it shouldn't be assumed that every coalition will achieve positive health ends. For example, the tobacco industry set up the Smoking Education Coalition, which worked to oppose local no-smoking laws.

"These Americans are a peculiar people....If, in a local community, a citizen becomes aware of a human need that is not met, he thereupon discusses the situation with his neighbors. Suddenly a committee comes into existence. The committee thereupon begins to operate on behalf of the need and a new community function is established. It is like watching a miracle."

Alexis de Tocqueville
1840

Coalition building

Coalitions are affiliations of people or groups with a shared purpose. They are partnerships working together collaboratively to influence outcomes on a specific issue.

3 Types of coalitions

A coalition is a partnership or union of people and organizations working with a shared purpose to influence outcomes on a specific issue. The following are working definitions of collaborative efforts. Although each has its own definition, many are used interchangeably.

- Advisory committees generally provide suggestions and technical assistance to an individual or institution, but do not make final decisions.
- Alliances and consortia typically have broad policy-oriented goals and usually consist of organizations and coalitions, as opposed to merely individuals.
- Commissions usually consist of individuals appointed by official bodies.
- Networks are loose-knit groups formed primarily for the purpose of resource and information sharing.
- Task forces often come together to accomplish a specific series of activities at the request of an overseeing body.
- Associations generally are formed by professionals or people with common interests; these tend to have a formal structure.

Coalition building examples

- Advisory Committees
- Alliance & Consortia
- Commissions
- Networks
- Task Forces
- Associations

4 The 8 steps to building and maintaining an effective coalition

The eight steps to building and maintaining an effective coalition are part of a framework for health promotion and a strategy for social change. It was initially developed for injury prevention advocates and practitioners. These steps do not always need to be taken sequentially. In fact, sometimes a situation requires that steps be conducted simultaneously or even skipped. There is no "right" way to develop partnerships. But it is very important to think critically and carefully about the order that makes sense depending on the circumstances—your group, your issue and your community.

Developing effective coalitions: The 8-step process

1. Analyze program objectives, determine whether to form a coalition
2. Recruit the right people
3. Devise preliminary objectives and activities
4. Convene the coalition
5. Anticipate necessary resources
6. Develop a successful structure
7. Maintain coalition vitality
8. Improve through evaluation

5 Step 1: Analyze the program's objectives and determine whether to form a coalition

When deciding whether or not to form or join a coalition, first consider whether it is the appropriate tool to meet your goals. Some tasks are inappropriate for coalitions because they may require quick responses. Coalitions are best used when broad scale support is needed, a diversity of views is beneficial, and/or there are multiple activities needed to achieve a solution. In some cases there is already a group working to achieve similar outcomes and it would be better to combine forces than to set up an alternative. Once you have decided that a coalition is needed, consider the resources required from the lead agency and from coalition members. Finally, consider whether or not coalition efforts represent the best use of these resources. There are times you may want to join an existing coalition with related goals instead of creating your own.

Developing effective coalitions

step 1

Analyze your program's objectives and determine whether to form a coalition.

- Clarify current objectives
- Examine approaches which might be effective
- Assess current community strengths and needs

The Strategic Alliance for Healthy Food and Activity Environments (Strategic Alliance) is an example of a statewide California-based coalition that came together to meet an identified need. Strategic Alliance formed in early 2000 to systematically address the changes needed in social, cultural and physical environments as well as in government policies and practices to ensure that healthy eating and physical activity are accessible to all Californians. The founding members of Strategic Alliance knew that by coming together, they could accomplish something larger and different than what they were doing alone. The formation of Strategic Alliance was not due to a funding mandate as is often the case with coalitions, nor was it to meet the needs of a particular program. Rather, the impetus for forming the coalition was to build a statewide movement around healthy eating and physical activity that shifted the frame from a sole focus on individual responsibility to the responsibilities of government, businesses and major institutions (such as healthcare) in shaping communities that support healthy choices.

Before choosing a coalition, it is important to examine objectives and determine specific strategies that could help achieve them. As a leader in a coalition, it is important to keep a mental vision of people whom you may never see at meetings. Think of those who contribute to the same goals as members of a "virtual coalition." Maybe they are people you talk to over the phone or members of subgroups. Remember that your coalition is made up of those who come together to achieve outcomes, not just those who come together around a table.

6 Step 2
Recruit the right people

Determine the membership type based on the coalition's goals. Most coalitions should have diverse membership. Start by identifying organizations that already work on the identified issue and look broadly for organizations and individuals that should be involved. Consider those who have influence, those who will be supportive and even those who may put obstacles in the coalition's path. Individual members may be community members, community leaders, or people who have directly experienced the problem. Unless there is a reason not to, it is a good idea to include individuals who are not affiliated with an organization, because they can perform functions that other coalition members may not easily be able to perform. For example, individual members may be perceived by the media as having less of a vested interest and therefore more credibility. Consider the question of whether to include opponents carefully. There are many reasons to include people who have a different perspective but many reasons and times they can interfere with the workings of a coalition, even destroy it. The criteria for whether or not to include opposition should be thought through carefully.

Developing effective coalitions
step 2

Recruit the right people.

- Identify people working on the issue
- Consider who has influence
- Determine who will be supportive
- Identify who may put obstacles in your path
- Consider how many people should be involved

The Farm and Food Policy Project is an example of a "coalition of coalitions." The Farm and Food Policy Project came together around the 2007 Farm Bill. The goal of the diverse group of stakeholders was to form a broader partnership representing different, but related, efforts to determine ways in which working together could effectively contribute to a farm bill that represents the needs of all coalition members — including food security, sustainable agriculture, nutrition, disadvantaged farmers, and anti-hunger groups. Like Strategic Alliance, the founding steering committee of the Farm and Food Policy Project decided early on that they needed to add more groups to round out their overall platform, in this case, groups working on physical activity. This led to a representative of a YMCA and a parks and recreation society joining the steering committee.

7 Step 3

Devise a set of preliminary objectives and activities for the coalition

In step one, the lead agency's objectives are examined in determining whether a collaborative was needed. In this step it is also important to create options to satisfy the interests, goals and decisions of all members, so that they feel included in the decision-making process. Some members, often including the lead agency, are more comfortable taking a long-term view, while others need to see more immediate success. Defining coalition goals and objectives, as well as deciding how to implement them, requires the inclusion of all coalition members in discussions.

Developing effective coalitions

step 3

Set preliminary objectives and activities.

- Propose a variety of activities to meet members' needs and skills
- Identify short-term successes

8–9

Long and short term goals

While working towards long-term goals, set some objectives and activities that can be addressed by all member organizations more immediately. Multiple stakeholder interest in short-term activities will reinforce commitment to the coalition, and may help garner increased community support. These activities will increase members' motivation and pride while enhancing coalition visibility and credibility.

A roadmap to achieving effectiveness and sustainability

Effective coalitions allow you to:

- Accomplish a broad range of goals
- Broaden buy-in
- Identify areas for focus
- Concentrate on *comprehensive* approaches

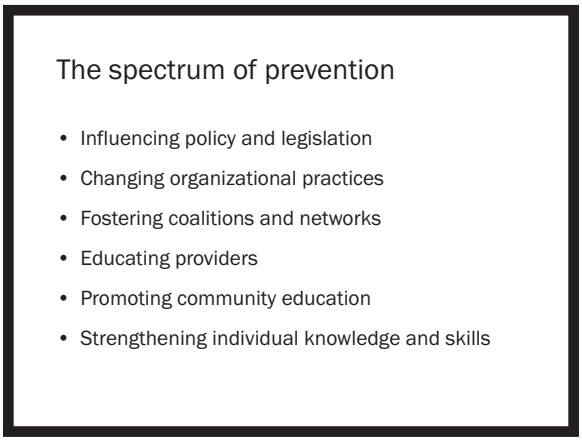
Recommendation

Reward members and celebrate success

- Provide recognition for members' efforts.
- Try this: Hold acknowledgement sessions during which coalition accomplishments are recognized.

10 The Spectrum of Prevention

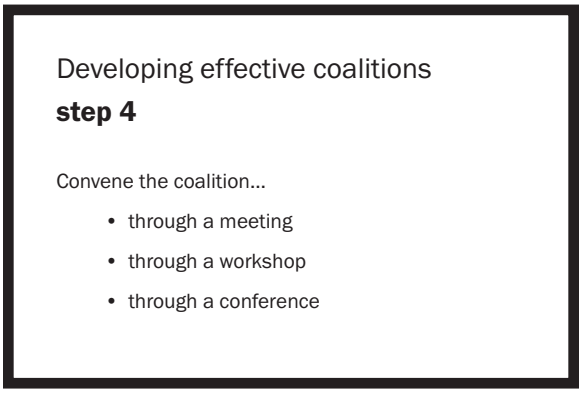
Designing coalition strategies to be comprehensive and multi-faceted is critical. One tool for doing so is the Spectrum of Prevention which identifies multiple levels of intervention including changing the practices of organizations and focusing on policy development. The Spectrum encourages people to move beyond the perception that prevention is only about individual education and enables coalition leadership and membership to clarify what is currently being done about an issue and to design a more complete set of strategies.



The more coalition activities resonate with the specific values and objectives of participants, the better. Each member should feel like a stakeholder and be proud of their individual contributions. In the case of the Strategic Alliance, for example, several different steering committee members each work on statewide policy development related to nutrition and physical activity. Each legislative session, Steering Committee members decide which of the policies championed by individual organizational members will serve as the legislative platform for the Strategic Alliance as a whole. This ensures a balance between the policies of individual steering committee members, which maintains buy-in, while also advancing the Alliance's long term goal of improving the nutrition and physical activity environment in California.

11 Step 4:
Convene the coalition

To ensure that coalition activities and goals are relevant to members, potential members should engage in a round-table discussion where they discuss their individual goals and reasons for joining the coalition. If you are convening the coalition for the first time, carefully select and talk with potential members to determine individual goals before sitting down with everyone at once. Commitments to the coalition should be withheld until members deem that the activities and long-term goals are worth it for them. Too often, coalitions are convened casually without a thorough consideration of who should be included. Coalitions require serious commitment and members should not be selected simply by who shows up. And for that reason, convening coalitions at the end of long conferences or workshops based on who stays around is typically not going to be a successful strategy.



12 Step 5:
Anticipate the necessary resources

Effective collaboratives generally require minimal resources for materials and supplies, but substantial time-commitments from people who are effectively staffing the coalition (whether in a funded or unfunded capacity). Mobilizing communities and building strong relationships will likely require members to engage in some of the following:

- Clerical work
- Meeting planning (including preparation and facilitation)
- Membership recruitment
- Orientation and encouragement
- Research and data collection
- Participation in activities and projects

Developing effective coalitions

step 5

Anticipate the necessary resources.

- Clerical
- Meeting planning, preparation and facilitation
- Membership recruitment, orientation and encouragement
- Research and data collection
- Participation in activities and projects

Periodic discussions about resources, support, and members' time limitations will reduce the risk of any member feeling overburdened or resentful of coalition work. Members should never be pressured to do more than they are comfortable with. At times, coalitions may decide to seek dedicated funding so that a staff person can maintain the day-to-day viability of the coalition. Such funding may come from contributions from individual coalition members and organizations, or better yet, through dedicated grant funding sought on behalf of the coalition. Coalition members should also think strategically about how their individual resources can best be used to meet the resource needs and goals of the coalition. For example, a violence prevention coalition in Salinas, California, included a representative from the city library. Through the research and data collection done by the coalition, literacy was identified as a key issue that could affect violence. The library realized that by providing everyone in the community with a library card without requiring any documentation in return, they could greatly contribute to the needs of the coalition while expending minimal resources of their own.

13-14

Step 6: Define elements of a successful coalition structure

Developing effective coalitions
step 6

Devise a successful coalition structure

- Should coalition be ad hoc or ongoing?
- How long and frequent should meetings be?
- Should agencies officially join the coalition?
- How will decisions be made?
- How will agendas be structured?
- How much will members realistically participate between meetings?

Although there is no one right way to put a coalition together, the anatomy of a coalition can make or break its success. Coalitions require thought and planning to ensure that their structure is conducive to coalition goals. In addition to thinking through elements of a successful coalition structure in the beginning, it is equally important to revisit the structure throughout the lifetime of the coalition and make changes as necessary.

The structure of a coalition typically is defined by its resources as well as its goals. For example, the Healthy Places Coalition is a California based coalition that advances public health involvement in land use and transportation planning to ensure that all neighborhoods in California promote the opportunity to live a healthy life. The Coalition consists of practitioners from the planning, public health, parks and recreation, and other related fields, community advocates, academics, and concerned individuals from around the state committed to social and health equity. Due to a lack of dedicated funding during the formation of the coalition, Healthy Places decided to form four independent subgroups, each tasked with formulating their own goals and activities to advance the mission of the coalition. The subgroups were: Media and Awareness, Research and Tools, Policy, and Collaboration. The subgroups ensured that individual members were spending their time strategically advancing the overall goals of the coalition by contributing their specific expertise rather than diluting efforts by having many general coalition meetings. Healthy Places also decided to review the structure after six months and make modifications as necessary.

Coalition life expectancy

The coalition's goals should dictate its longevity. Although coalition leaders tend to want the coalition's timeframe to be open-ended, member organizations and their representatives often prefer coalitions with a specific life expectancy. However, when long-standing credibility is a vital goal, an ongoing coalition might be needed. There are many cases where working together with a short and specific timeframe (e.g. a year) will produce more vitality and results than an ongoing coalition.

Meeting location, frequency, and length

To promote an atmosphere of equal contribution, coalition meetings may be held on neutral territory, such as the local library. Rotating the meeting to different members' sites can add interest, although at times also confusion. The geography of the room, where people sit and the atmosphere, also contributes to productive meetings. If you are hosting a meeting, consider these things as criti-

cal elements to success. Other than an ad hoc emergency situation — such as a legislative deadline — coalitions typically should not meet more frequently than once a month. It is often a good idea to shift meeting locations amongst the various coalition member organizations. This small change can help foster the sense of connection and responsibility the hosting member feels to the coalition.

Membership parameters

Coalition members must play a role in decisions about the extent to which new members will be invited and how defined or open the membership should be. In many cases, a compromise solution in which certain people are recruited and encouraged, but virtually no one is excluded, is best. More formalized membership procedures may become an issue when and if the coalition wishes to make public statements or endorse policy measures; otherwise, less formal procedures are preferable.

Decision making methods

Usually when coalitions are working well, decisions are made informally and spontaneously and arise through the discussion. When overt decisions must be made they should if possible be made by consensus. Research on community-based coalitions has suggested that this process reduces impulsive decision-making and improves stakeholder participation. To avoid stalemates, define consensus as an approach that the majority supports and others can live with. There will be cases in which consensus cannot be reached and the group must either vote or accept that there will be no action on a certain issue.

Meeting structure

A clear and reasonably consistent agenda, which may be modified by those present at the beginning of the meeting, can reinforce the coalition's purpose and foster collaboration. The skill of keeping to the agenda but being flexible and open to new ideas is a vital one in maximizing meeting success. Coalitions should avoid the temptation to start every meeting by having members introduce themselves and their individual organizations as these lengthy introductions can often take up the space of the entire meeting, leaving very little time for actual work to get done. Instead, coalitions should decide when specific updates from individual members are strategically necessary and how to best orient new members to the coalition.

Meeting agenda

- Welcome & Intros
- Review minutes & action items
- Key items for discussion
- Updates from subcommittees
- Legislative and policy items
- Brief updates from participants on upcoming activities events
- Evaluation of meeting set next meeting

Participation between meetings

Successful coalitions often have subcommittees, which carry out specific coalition activities. Subcommittee members should not be expected to contribute more than a few hours between meetings. The most active and strategic participants in the coalition may want to form a steering committee, which provides

leadership by discussing long-range goals and the tactics to achieve them. A steering committee often works well as an informal open body. Needless to say, people volunteer at coalition meetings and do not always follow through. This is to be expected and if follow through is vital, it should be monitored and assisted by staff.

15 Step 7: Addressing coalition difficulties

One clear indication that a coalition is having difficulties is a decline in coalition membership. Conflicts of interest, overlapping efforts, and confusion over roles, may all lead to the loss of collective voice within a coalition. Early warning signs include repetitious meetings; meetings that become bogged down in procedures; significant failures in follow-through; disunity between members; lack of enthusiasm; or an unacceptable drain on lead agency resources. Turf struggles are perhaps the most commonly identified explanation when vitality sags. Turf struggles are a common threat to coalition vitality and success. There are few examples of coalitions, especially long running successful coalitions, which have not at one time experienced some form of coalition difficulty. Acknowledging that these difficulties are part of the reality of a coalition is a key step to overcoming them.

Developing effective coalitions
step 7

Maintain the coalition's vitality

Difficulties generally arise due to:

- poor group dynamics
- inadequate membership participation
- ineffective coalition activities
- external changes which affect the coalition's mission

16 There are three categories of turf struggle:

Coalition Member vs. Coalition Member:
When conflict between coalition members is related to historical tensions between organizations or sometimes personality conflicts between individuals. This is the most frequent type of turf struggle.

Coalition Member vs. Coalition:
As a coalition gains visibility and starts to apply for funding, conflict can develop between individual coalition members and the coalition as a whole because of increased competition for resources.

Members vs. Lead Agency:
Lead agencies can sometimes benefit most from the work of the coalition, leading to tension among the members that they are helping the lead agency, often at their own organization's expense. Lead agencies need to be proactive to ensure these issues are dealt with thoughtfully and fairly.

Types of turf battles

Member vs. member:
often unrelated to the coalition

Members vs. coalition:
members compete for the same pool of resources as the coalition

Members vs. lead agency:
lead agency may acquire resources at the expense of individual members

17-19

Turf issues

Instead of instructing members to "leave turf at the door," a more realistic approach acknowledges that turf issues will challenge the group and blends the pursuit of individual interests with the greater goals of the coalition. In addition to some of the suggestions for maintaining membership buy-in and enthusiasm, the following are ways coalition leaders can deal with turf battles and tensions.

Acknowledge potential turf issues

Choose coalition representative whose job descriptions and personalities make them less influenced by the past.

Build bridges

Maintain an environment fostering trust, respect and amicability among coalition members, through a friendly tone, small workgroups, and post-meeting socializing.

Remind participants of the big picture

Make space in a meeting where a coalition member dedicated to the coalition's cause, such as a survivor, youth or faith leader, can re-motivate members.

Make struggles overt

Acknowledge that conflict exists and discuss potential causes of the conflict so that it does not fester and drain the vitality of a coalition.

Encourage flexibility

Create an open environment where members feel comfortable with diverse perspectives and with conflict.

Why do turf issues arise?

- Coalitions tend to be made up of passionate members
- Non-coalition related issues are brought into the coalition
- Conflicting agendas
- Previous bad relations
- Control over the coalition (identity, ideology, and strategy)
- Who gets recognition and resources

Recommendation

The big picture

- When turf issues arise, utilize perceived neutrality of certain members (youth, survivors) to bring the coalition back to its purpose.
- Try this: If the chair senses turf issues are arising, space should be made during a meeting for a speaker who can remind the coalition of its purpose.

Recommendation

Make struggles overt

- Turf battles can only be addressed if members admit that they exist. Acknowledge that conflict exists and discuss potential causes.
- Try this: Coalition leadership should set the tone that turf is "not a four letter word."

Step 8:
Make improvements through evaluation

Evaluating a coalition can lead to changes in a coalition's approach. In addition, evaluation can increase a coalition's effectiveness and can assure that the community and participants benefit from the coalition's activities. Taking the time to evaluate the effectiveness of coalition efforts is a way of acknowledging that the skills and contributions of coalition members are important and assures that the coalition grows from its experiences, regardless of the programmatic outcome. Furthermore, when a coalition modifies its efforts to eliminate problems pinpointed by an evaluation, the coalition's credibility can improve significantly. Coalitions can employ two basic types of evaluation, formative and summative evaluations.

Developing effective coalitions

step 8

Make improvements through evaluation.

- Ask for feedback
- Evaluate the effectiveness of specific activities
- Know when it is time to dissolve, disband, or change the structure of the coalition

21-22

Coalition evaluation

Coalition evaluation is a newly emerging field, and is much more difficult than simply determining if a program is effective. Because coalitions aim in many cases to achieve multi-faceted environmental change, change is hard to see and the role of the coalition difficult to measure. To ensure that evaluators advance the important work that collaboratives are engaged in requires melding existing evaluation skills with a new way of thinking.

Formative evaluations

Formative evaluations focus specifically on the coalition's process objectives. For example, a coalition may want to encourage the media to promote a particular goal. A formative evaluation would analyze the process by which the coalition attempted to achieve this goal.

Summative evaluations

Summative evaluations help coalition members determine whether or not the coalition's strategies resulted in the desired consequences.

Whereas coalitions are powerful tools for getting things done, coalitions are only as strong as the time and planning that goes into forming and maintaining them. Using the 8 steps delineated above, prior to the formation of a coalition as well as during the course of an existing coalition, will go a long ways towards creating a coalition that effectively achieves its desired goals while also advancing the individual work of coalition members.

Types of evaluations

Impact evaluation assesses the *ultimate effect* of program activity on a specific community or target group.

Outcome evaluations assess whether the *specific interventions* had the intended impact.

Process evaluations monitor and document the *specific activities and interactions* taken to achieve a given outcome or impact.

Evaluation of collaboratives examines:

- Effective partnerships
- Collaborative achievements
- How to further strengthen collaboratives

discussion questions

These discussion questions ask students to brainstorm and share ideas about how to build and maintain successful coalitions and how to solve problems as they arise:

A Think about groups you've been part of:

- How did your group recruit new members? What was needed to successfully achieve a diverse membership that helped advance the goals of your group? Is there anything you would now do differently?
- Think about a group you've been part of which started to flounder, what were the warning signs you saw? Did you see those warning signs at the time? In hindsight what might have been done better?

B Come up with an issue or policy you would like to see changed.

- What organizations would you reach out to initially?
- How would you define goals? Brainstorm in the classroom about the kinds of resources and staff needed to form a coalition around that issue.
- What turf struggles might potentially arise? Between which groups? How would you address these tensions before they fully develop?

C Choose a policy goal that a coalition might be formed to achieve it. How should the coalition evaluate success? When should this evaluation process be initiated and what criterion should be used to determine success or failure?

skills-building exercise

Divide the students into small groups. Ask each group to discuss one of the following scenarios. After a 25-minute discussion, students should present problems and solutions to the classroom community.

1 There is a corner store in your neighborhood that does not sell fruit or vegetables, but does sell plenty of alcohol and prominently displays alcohol advertisements. Your neighborhood is already disproportionately affected by diabetes and other food-related chronic illness. If you decided to form a coalition to address this problem, what community groups would you involve, what sectors of government would you contact, and what would the coalition's objectives be?

2 You and a group of others have come together to discuss the fact that for the third time in a month there has been a violent incident in the neighborhood. The police have been unresponsive to individual complaints and now the group is looking for ways to address the increasing violence. How should you decide whether a coalition is needed? If so, what members should be invited to join?

3 You live in a building where there is a growing concern about asthma-causing mold inside of people's apartments. As it turns out, asthma and the mold that can cause it is prevalent throughout the neighborhood. If you were a tenant and wanted to organize around this issue, what organizations would you reach-out to initially? What resources and staff would you need? Design a set of strategies along the spectrum of prevention.

4 Read the newspaper and select one high-profile issue that could benefit from a coalition. What would the objectives of the coalition be and what would the agenda for the first meeting look like?

5 Motorcyclists have organized to repeal California's motorcycle helmet law, even though the legislation has reduced deaths and serious injuries, as well as costs associated with crashes, by 50%. Because of the law's success you believe it's key to maintain the effort. What groups would you call to the table to start forming a coalition? What would the coalition's objectives be? How often would the group meet? How long would the meetings be?

6 Imagine your group is part of a coalition which has formed to address domestic violence in your community. Lay out strategies along the Spectrum of Prevention and the kinds of members needed to achieve them.

assignments

1 Project: Analyzing a Coalition:

This assignment requires students to choose a coalition in their field of interest and to get to know its inner workings by interviewing members and lead agencies, as well as sitting in on as many meetings and subcommittee meetings as possible. Students will research and write a paper that is an overview of the coalition—history, successes, challenges, failures and present goals.

Questions students should consider and ask in interviews should include:

- Why did each particular organization or member join the coalition and when?
- Was there a particular activity that drew them to the coalition? How did the coalition's goals compare with the particular member or organization's goals?
- How much time does each organization or member contribute to coalition activities?
- What challenges have arisen? Has any one member or group felt competition with others or with the coalition as a whole?
- How does each member or organization envision the trajectory of the coalition?

The final paper should be a seven-page summary in which students use at least three readings to help understand their findings in the field. Students should use quotes from interviews to help illustrates the views and ideas of coalition members, as well as any observations they have had at meetings or during other coalition activities.

2 Project: Forming a Coalition:

This assignment asks students to choose an issue of concern and form a hypothetical coalition around it. Students will submit a 5-7 page proposal describing how and why they would form a coalition. It should include:

- A one-page summary of why the student has chosen to form a coalition around the particular issue or goal.
- A description of each member organization they will ask to join and why they are being included. What will each get out of the coalition, how can each contribute?
- An agenda for the first meeting.
- A description of one long-term and one-short term activity along with a plan that lays out how members might work together to achieve each. What pitfalls might arise and how can negative impacts be mitigated?

possible guest speakers

- Local elected officials
- Local advocates
- Coalition members from your community
- Local advocates working on health and healthcare issue (preferably involved in at least one coalition)

required reading

Butterfross F. Essential coalition processes (chapter 7). *Coalitions in Community Health*, Jossey-Bass: San Francisco, 2007.

Cohen L, Chavez V, and Chehimi S (eds.). Working collaboratively to advance prevention (chapter 7). *Prevention is Primary: Strategies for Community Wellbeing*, San Francisco: Jossey-Bass, 2007.

Cohen L, Swift S. The spectrum of prevention: Developing a comprehensive approach to injury prevention. Injury Prevention, 1999; 5:203-207.

Minkler M. Understanding coalitions and how they operate as organizations. (chapter 16). *Community Organizing and Community Building for Health*. Piscataway, NJ: Rutgers University Press, 2005.

suggested reading

Cohen L, Chavez V, and Chehimi S (eds.). Beyond brochures: The imperative for primary prevention (chapter 1). *Prevention is Primary: Strategies for Community Wellbeing*, San Francisco: Jossey-Bass, 2007.

other resources

"The Democratic Promise: Saul Alinsky and His Legacy." (1999) 56 minutes. This PBS program looks at Alinsky's work in community organizing with labor, civil rights and religious leaders, and how his methods are used today. Filmmakers Bob Hercules and Bruce Orenstein; narrated by Alec Baldwin, Chicago video project.

Asian and Pacific Islander Institute on Domestic Violence.
http://www.apiahf.org/apidvinstitute/GenderViolence/community.htm

Strategic Alliance for Healthy Food and Activity Environments
http://www.preventioninstitute.org/sa/

8

Media Advocacy

introduction

The history of public health is clear: Social conditions and the physical environment are important determinants of health. The primary tool available to public health for influencing social conditions and environments is policy. Policies define the structures and set the rules by which we live. If public health practitioners are going to improve social conditions and physical environments in lasting and meaningful ways, they must be involved in policy development and policy advocacy. And, being successful in policy advocacy means paying attention to the news.

In our society the news media largely determine what issues we collectively think about, how we think about them, and what kinds of alternatives are considered viable. The news influence extends to policy decisions on health. In particular, news portrayals of health issues are significant for how they influence policymakers and the public regarding who has responsibility for preventing and treating health problems. Issues are not considered by the public and policymakers unless they are visible, and they are not visible unless the news has brought them to light.

Nonprofit organizations and community activists often are unhappy with the way their issues are presented in the news, and typically respond by criticizing the media, ignoring it, or even becoming hostile. These responses are nonproductive because they cede power over the public portrayal of their issues to journalists, while also widening

the gulf between journalists and advocates. Media advocacy addresses this problem. It is a new approach to health communication that differs significantly from traditional mass communications approaches. Media advocacy helps people understand the importance and reach of news coverage, the need to participate actively in shaping such coverage, and the methods to do so effectively.

If public health-oriented solutions are to be given full consideration, then advocates talking to journalists, and journalists themselves, must understand how to frame issues from the perspective of shared accountability so that news coverage is not focused exclusively on individual responsibility. This shared accountability recognizes that health and social problems will only be adequately addressed when all sectors of society — not just the individual — share responsibility for solutions. Media advocacy emphasizes institutional accountability, which typically receives less attention from the news than individually-oriented solutions.

Public health practitioners tend to overlook the power of the news media to influence change. Journalists themselves, even when committed to covering social problems, often produce stories that emphasize individual behavior and treatment rather than social factors and prevention. Despite mass media's enormous reach and potential as a tool for change, public health professionals rarely use it to its full advantage. Rather, they tend to use it in its least effective capacity: to convey personal health information to consumers. By contrast, media advocacy harnesses the power of the news to mobilize advocates and apply pressure for policy change.

learning objectives

The purpose of this lesson is to provide students with an understanding of how mass media can be used as part of an advocacy strategy to promote healthy public policy. The primary focus of the lesson is on doing "media advocacy."

In this lesson students will learn how the news media operate, and will gain experience in framing issues from a public health perspective so they can become skilled in working with journalists to get news attention for public health solutions to social problems. By the end of this lesson and completion of all assignments, students will be able to:

1. Assess how strategic communications can further public health goals
2. Explain the role of mass media in setting the public agenda and framing public health issues, typical news frames for public health issues, and how news might contribute to public health problems
3. Identify the particular perspectives, potential, challenges, and theoretical underpinnings of media advocacy, including strategies to access the media, framing public health problems as social issues, and advancing public policy initiatives
4. Reframe personal health problems as upstream public health issues, and
5. Communicate arguments, make an advocacy case, and contribute to the public debate about public health issues on an ongoing basis.

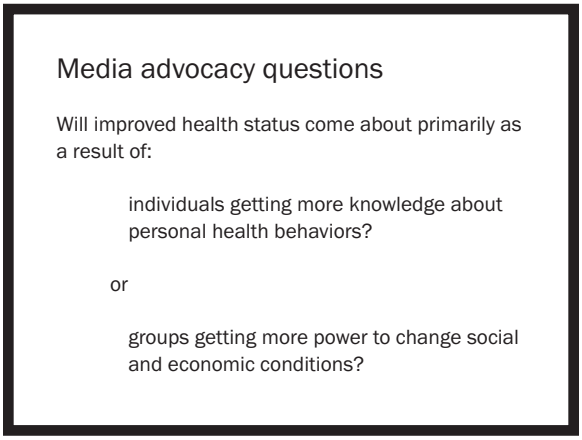
key points to be made in lesson

1 Lesson goals

In this lesson we will cover the basics of media advocacy, an important tool for policy advocates. We will compare media advocacy to other health communication strategies, and delve into the tactics that media advocates use to put their issues at the top of the agenda, framed from a public health perspective. The overall goal is to prepare students to integrate media advocacy into their future policy efforts.

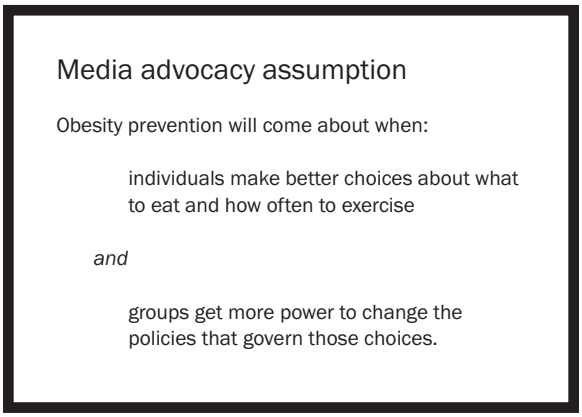
2 Media advocacy questions

The fundamental question we need to address is: Will improved health status come about primarily as a result of individuals getting more knowledge about personal health behaviors, or as a result of groups getting more power to change social and economic conditions? Depending on how we answer, we will use media approaches that focus on delivering information or "raising awareness" or the newer media approaches that use media as a power tool to put pressure on policy-makers. The history and scientific basis of public health provide a clear answer to this question. The more social and physical resources that people have, the better their health status. While many in public health will agree that the best chance for improvement in a population's health status rests with the second question, much of public health practitioners' time and resources are spent on the first. Most interventions in public health are focused on the individual; they target the person with the problem. Media advocacy is one tool for working on the environment, not just the person.



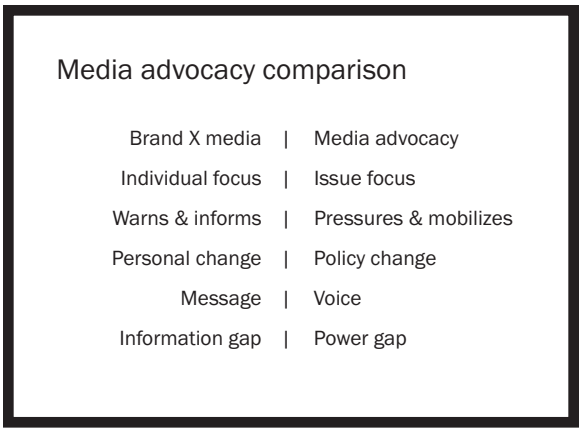
3 Media advocacy assumption

This is not an either/or proposition. Both individual education and broad environmental changes are necessary. Usually, however, the environmental perspective gets short shrift. *[Instructor: Ask the students "why" to engender a discussion about the political nature of the questions; the first option is usually non-controversial, while the second is often highly controversial. You might also substitute a similar comparison for any public health issue.]*



4 Media advocacy comparison

Media advocacy differs from other health communication techniques. The fundamental difference lies in how we have traditionally used the media, as well as what we have to do to meet contemporary challenges. Traditional media strategies have focused on individuals with the goal of warning them about a danger or informing them about a behavior that, if adopted, can improve their health. The objective according to this perspective is to foster a personal change. The communication goal, as discussed in Lesson 1, is to deliver the right message, in the right way, to the right person, at the right time, so that s/he can make the right choice and do the right thing for her/his health. If more individuals do this, or so the logic goes, we would have a healthier society. The assumption underlying this model is that what is causing a given health problem is a lack of information. Once properly delivered, the right information can correct the problem.



Sometimes this works. For some people, hearing just once or twice that exercising a few times a week could extend their life and improve their health is sufficient to prompt them to begin to exercise regularly. But, unfortunately for many people, simply knowing that fact is not enough. Information is necessary, but not always sufficient, for widespread changes in health behaviors. (Note that this conception simplifies the issue somewhat; we will discuss the nuances, and the contributions of social marketing, in a moment.)

In contrast, media advocacy is focused not on individuals with health problems, but on broader social issues. The objective is to use communication as a pressure tool to highlight particular solutions to public health problems, usually policy solutions. The media tactics elevate the issue on a decision maker's agenda, and mobilize those groups that can put pressure on the decision maker. The objective is to use communication tools to help communities raise their voices, as opposed to using

communication strategies to deliver a message from on high. The assumption underlying this approach is that there is a power gap between communities that suffer most from public health problems and those who can create healthier environments (again, usually with policy).

The key difference is how the problem is conceptualized. With traditional "Brand X" media strategies, the problem is contained in the body of the person. With media advocacy, the problem is contained in the body politic.

5 Media advocacy shifts focus

Reconceptualizing communication strategies to address the environment means moving from a problem defined at the individual level to a problem defined as a social problem at the population level. It means moving from a short-term focus on programs to a longer-term focus on policy change. The biggest shift comes in how public health might identify the "target audience." In most public health interventions, the target audience is the person with the problem. With media advocacy, the target audience is the small but powerful group that holds the policy levers for environmental change. Media advocacy treats people in the community as citizens with a say in how their environment is structured, rather than as passive consumers of information and instruction. Ultimately, the shift means using communication strategies not simply to change health habits, but to influence policy.

Media advocacy shifts focus

from	toward
Problem defined at individual level	Problem defined at policy level
Short-term focus on programs	Long-term focus on policy
Treating people as consumers	Treating people as citizens
Using mass media to change health habits	Using mass media to influence policy

6 Social marketing

In general, social marketing's purpose is to change personal health behavior. While it claims a much larger terrain that recognizes environmental influences on behavior, when it is practiced in this country most of the time it is focused on individual behavior. A major contribution from social marketing has been the development of formative research to determine how best to appeal to and motivate the target audience. Techniques such as focus groups have greatly improved social marketers' abilities to reach specific audiences and tailor messages. However, broad population-level behavior change still remains an elusive goal.

Social marketing

Purpose: change personal health behavior

Focus: increase knowledge, awareness, motivation

Target: individuals with risk factors

Tactics: use marketing's "four P's" to reduce barriers and increase perceived benefits of desired behavior

7 The social marketing mix

In the 1950s, Philip Kotler developed the concept of the Four Ps of Marketing: Product, Place, Promotion, and Price. Marketers adjust each of these components to arrive at a mix that will influence customers to choose their products over a competitor's. When applied in a health context, the product becomes the desired behavior change; the price is the social or other cost associated with attaining that behavior change; the place is where the new behavior might be practiced or learned; and promotion is the education and information delivered to attract new audiences to the behavior (i.e., the "warn" and "inform" discussed earlier).

The social marketing mix

Purpose:	the desired behavior
Price:	the financial, social and other costs of the behavior
Place:	the distribution channels affecting physical and social availability of the "product"
Promotion:	how the target audience is made aware of the product and motivated to adopt it

Using the Four Ps to prevent nutrition-related disease, for example, a social marketer might highlight healthy eating by identifying and promoting a new eating pattern, such as eating five fruits and vegetables a day (as in the national "5-a-Day" campaign). The product, in this example, is the new eating behavior. To decrease the price, a social marketer might work to make fruit and vegetables more desirable by creating tasty, simple recipes; or, a social marketer might work to decrease the actual costs of the produce. To address place, a social marketer might introduce fruits and vegetables where they are easier to access, as when the Kaiser Permanente health plan in California instituted weekly farmers' markets. Finally, a social marketer would promote the idea of eating "5-a-Day" with general information campaigns, or related to other specific strategies, like publicizing the farmers' market.

An interesting take on the Four Ps comes from public health advocates who have challenged the marketing practices of tobacco, alcohol, and food companies. These advocates used the Four Ps to think about how to address the marketing tactics, themselves. For example, tobacco control advocates have worked to raise excise taxes (price), reduce the number of places where smoking is allowed (place), and eliminate advertising on TV (promotion).

8 The media context

Whatever message is finally developed is going to be heard in a messy, loud media context that is dominated by well-financed campaigns from corporations, some with "anti-health" goals. Public health can never compete in this message environment; we simply do not have the resources in most cases. The marketing campaign for a single candy bar, for example, can outspend the entire national 5-a-Day campaign. Therefore, we need to be strategic.

The media context

9 Public relations

Public relations is usually thought of in a corporate context. The idea is to manage how the public, and ultimately government, "sees" the organization. It is in this context that the idea came to be that any media coverage is good coverage "as long as they spell your name right." Public relations has become very sophisticated, with large firms paying close attention to how various companies and products are portrayed in the media. In the corporate world, public relations staff usually work closely with government relations staff.

Public relations

Purpose: nurture the professional and social environments that support the organization's mission

Focus: promote the organization

Target: customers and clients, supporters and funders, public

Tactics: develop media relationships, generate press releases and fact sheets, get in the news

10 Media advocacy

Media advocacy can look similar to social marketing and public relations, because at the tactical level, all three approaches can use the same techniques. Media advocates, social marketers, and public relations people all might have a need to issue a news release, for example. What separates the three approaches is their fundamental purpose. Media advocacy's purpose is to put pressure on policymakers to create healthier environments.

Media advocacy

Purpose: put pressure on policy makers and reframe public debate

Focus: set the agenda and shape the story to include policy solutions in news coverage of the health issue

Target: policy makers, other advocates, community members

Tactics: news coverage, editorial page access, some paid advertising

11 Media advocacy definition

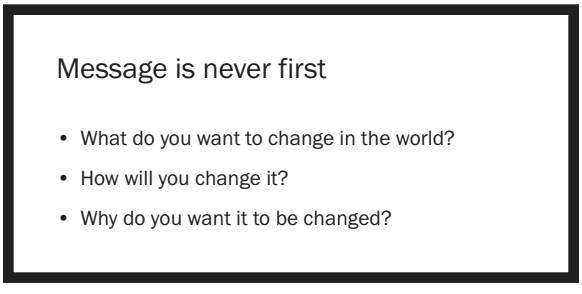
Media advocacy is one tool for working on the environment, not just the person. *Strategic* means being proactive in getting the type of news coverage that will support your advocacy goals at the right time. Sometimes it means choosing *not* to use media. Either way, it means knowing your advocacy goals and target before talking to the media. Media advocacy is one part of an advocacy strategy, not an end in itself. Therefore, the expectation is that media advocacy will *support community organizing*, not replace it. Similarly, media advocacy is aimed toward *advancing policy* solutions that change the environment to support health. Since the goal is changing policy, the target for media advocacy is specific policymaker(s), not the general public or the people with the health problem.

12 Layers of strategy

Media advocates plan their work in four stages: overall strategy, media strategy, message strategy, and access strategy. Once you know what you want to see happen (usually a policy change), and who can make the change happen (the primary target), and you have enlisted those who can put pressure on your target (all part of the *overall strategy*), then you are ready to figure out what you want to say to help the target see why your change will improve community health (the *message strategy*). *Access strategy* answers the questions: How will you get media coverage? What could make this issue newsworthy? What can you provide a reporter to make this story easier to tell (e.g., spokespeople, visuals, social math)? Note that order is important here. You cannot figure out an appropriate access strategy until you have determined the first three layers of strategy.

13 Message is never first

Media advocacy is always embedded in an overall strategy. Even though message is important, it should never be your first consideration. It has to grow out of the change you want to see in the world. Moreover, it will be a better message if it is anchored in your values; the reason you want to see the change in the world.

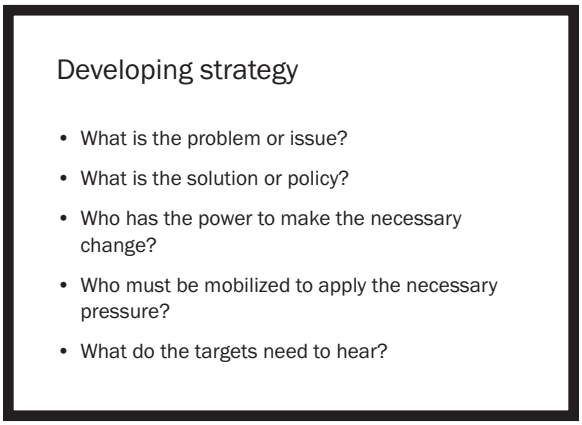


14 Developing strategy

Your strategy will determine how to approach the problem, and thus also how to approach the media. Media advocacy is only a tool for policy advocacy — "only," because it is easy to be distracted by the drama and reach of the media.

Develop your strategy by answering the following questions:

- *What is the policy solution?* Media advocacy is focused on policy change, thus creating an environment in which people can be healthy.
- *Who are the decision-makers with the power to make the change?* When the goal is policy, the target is not the person with the problem. Who your target is (e.g., legislature, city council, business, school board, principal, mayor, building manager etc.) depends upon your particular policy goal.
- *Who must be mobilized to apply necessary pressure?* Who cares about this issue, and who will the target listen to? These are the secondary targets. The "general public" is not specific enough to be a target audience; media advocacy is not about raising awareness among the general public, but about sparking action among particular power-holders.
- *What do the targets need to hear?* What they need to hear, and from whom they need to hear it, are the foundations for your message strategy.

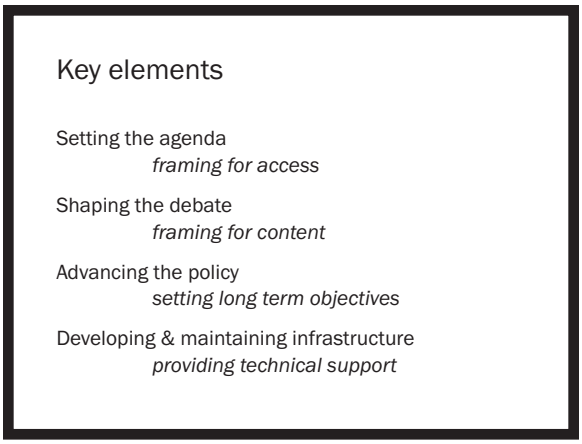


15 Media advocacy players

Media advocacy is a political strategy, and as such, can be confrontational. Not everyone will be able to take on the "out front" role in a media advocacy campaign. In fact, most campaigns comprise a coalition of groups that take on different roles and responsibilities, sometimes behind the scenes. *[Instructor: Ask the class how they might envision the different roles listed on the slide played out in a policy campaign. Ask for examples of other roles. Have students discuss why an epidemiologist might be restricted in what he or she would say to the press in a way that a community organizer might not.]*

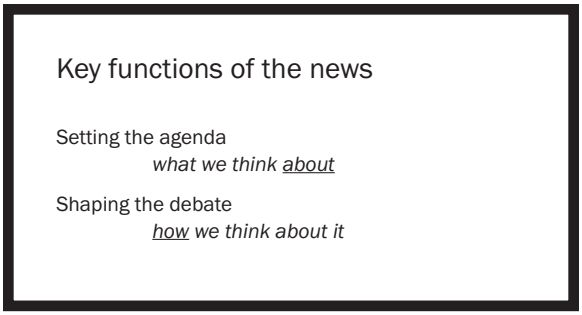
16 Key elements

Media advocacy focuses on four key elements: 1) setting the agenda for the public and policymakers through the news, or what we call "framing for access"; 2) shaping public debate so it focuses on specific policy solutions, or what we call "framing for content"; 3) advancing policy over the long term, which requires integration with community organizing and policy advocacy strategies; and 4) developing an infrastructure to carry out campaigns over time, as most policy change takes years.



17 Key functions of the news

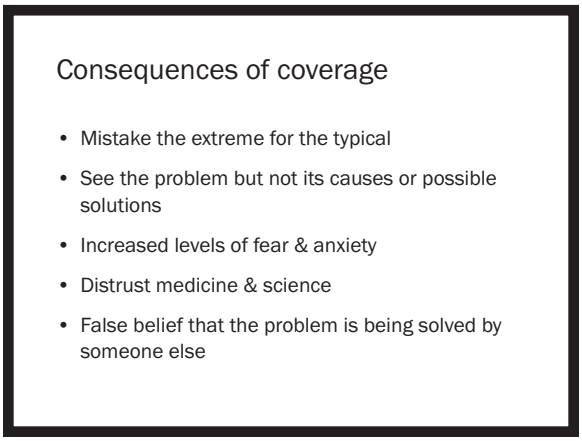
Decades of communication research shows that the news sets the agenda for the public, for policymakers, and for the news industry, itself. The media accord legitimacy and credibility to the issues they cover. News reflects issues of the day, but also selects what people and policymakers discuss. And, by setting the public agenda, the media also select what is *not* being discussed. This is one way that the news media shape public debate, by narrowing the topics under discussion. But importantly, the *way* the media present an issue also shapes *how* people think about it, especially in the absence of personal experience. How problems are discussed influences what solutions seem appropriate (for example, whether problems should be solved by personal behavior change and/or policy action). Policymakers see news as barometer of public concerns. Since the news is a primary way to reach decision-makers, media advocates need to determine what they want done about a problem, and by whom (their overall strategy), before talking to reporters. As an advocate, it is not enough to get your issue on the public agenda. How it is framed in the news matters for getting policymaker support for your goals. That is what "shaping the debate" is about.



[Instructor: Ask students about their own experience with the news: Who had a conversation this week based on a news story? Whose issue was not in the news this week? Who learned about something in the news with which s/he did not have personal or professional experience? Has a policymaker (i.e., elected official, public health department, school principal, etc.) ever contacted you to discuss a problem s/he heard about in the news?]

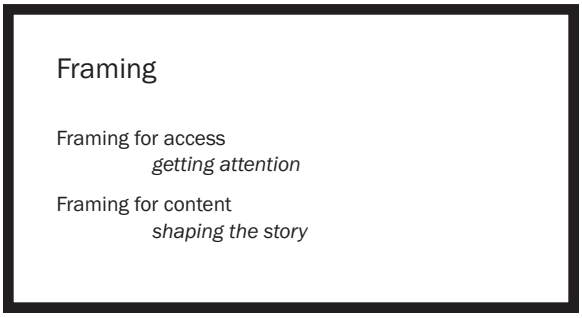
18 Consequences of coverage

Through content analyses and experiments with audiences, researchers have found that, unfortunately, the news generally provides a distorted view of the world. The patterns in these distortions are consistent across time and issues. In crime and violence coverage, an area that has been well-studied, it is clear that audiences think the world is a far more dangerous place than other relied-upon indicators suggest it is. The most common crimes are the least reported, while the rare but extreme crimes are widely reported. In addition, news stories tend to describe problems, but not solutions. Together, these features have the effect of increasing fear, as well as increasing distrust in authorities, such as those from medicine or science.



19 Framing

Media advocates think about two types of framing; what you emphasize to gain the attention of reporters (i.e., framing for access) may not be what you emphasize once you have their attention (i.e., framing for content). For example, in injury control the dominant frame is that injuries are inevitable, accidental, and thus probably unavoidable. Framing for content means you shape the story to emphasize that injuries are predictable and thus can be prevented (at a population level, if not an individual level). But first, to gain access to reporters so you can make your points about injury and connect them to your policy solution, you will have to identify what is newsworthy about the story, *now*. That means creating news, which is one of the general tactics we will turn to in a moment.

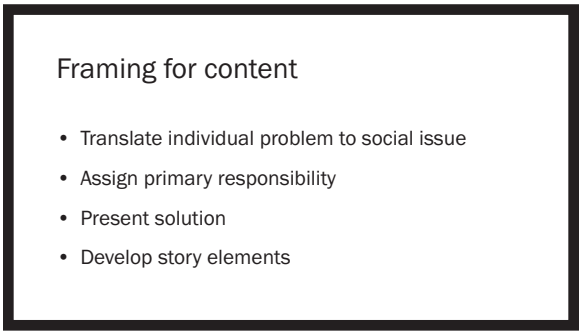


20 Framing for access

To get a reporter's attention, or frame for access, media advocates pay attention to those tenets of newsworthiness that grab journalists' attention. *[Instructor: Ask students for examples, drawn from current events, of each of the tenets listed on the slide. Then, ask them to identify a tenet of newsworthiness for a public health issue on which they currently work.]*

21 Framing for content

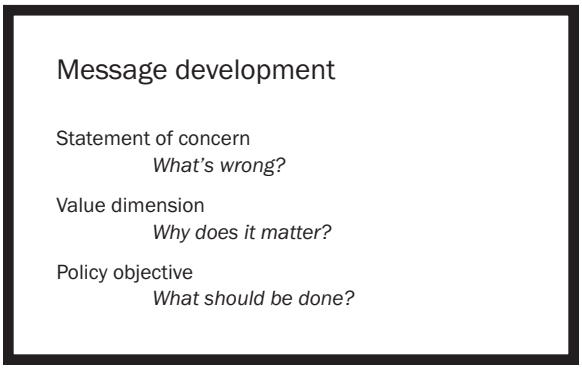
Tobacco is a terrific example of reframing. First it was thought of as a personal problem of smokers who were addicted. Then it was reframed so it was understood as a problem of corporate behavior and government regulation, rather than the behavior of the smoker. Once advocates brought that about, everything else was understood differently:



- Tobacco: A problem of corporate behavior and government regulation, rather than the behavior of the smoker
- Responsibility: Belongs to the tobacco industry and those who regulate it
- Solution: Policies on availability and youth access (e.g., vending machines, etc.), excise taxes, and advertising
- Appeal: Policies save money, protect youth, promote health, and burden industry, rather than victims
- Story elements show rather than tell, whether the news story is for TV, print, or the Web. Use story elements to communicate your frame, and the values underlying your frame.
- Advocates with good story elements increase their ability to influence how a news story gets told. Story elements for tobacco include images (e.g., tobacco advertisement copy, images of youth, jumbo jet, former smokers, community advocates), and symbols (e.g., fairness, health, freedom, death, youth, etc.).

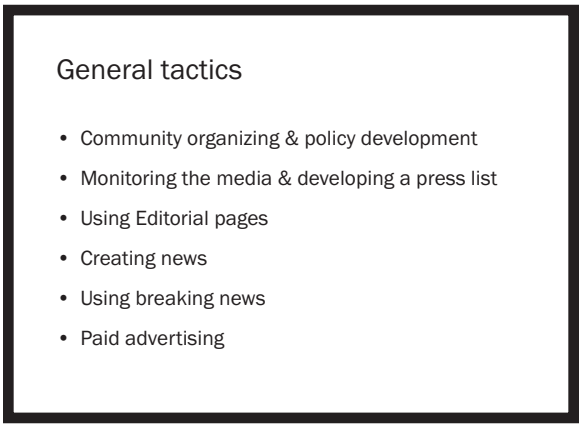
22 Message development

A message has three components: a problem statement, a solution, and a values statement. By now these questions should look familiar, because the message will be derived from the overall strategy. There might be several correct answers to these questions, so media advocates must be strategic and choose the answers that link to the current status of the overall strategy. Advocates must be able to articulate all of the following: why this problem and solution matter; which values support this goal; and what will happen if nothing is done.



23 General tactics

There are just a few general tactics that one uses in media advocacy. The first step is to learn about your media. Who covers health stories? What are their interests? Send these reporters some material, get in their resource files, and give them a call. Creating news can happen in a variety of ways. You can issue a report, conduct a study, protest something, announce a new program, etc. There are a number of ways you can use breaking news to get access to the media. The cyanide and Chilean grape boycott example is a classic. If you can anticipate breaking news, such as a Surgeon General's report or press conference, you can plan based on this. Paid advertising is also a key strategy.



24 Talking with journalists

Interviews with reporters will differ depending on how far along the reporter is in researching the story. For example, reporters differentiate between their gathering and assessing information (reporting), and what they do with that information (writing). Early in the reporter's process, you may be asked to provide background and give a general overview in addition to adding your perspective on a problem. Later on, after the reporter has talked with all the stakeholders, he or she may return to you or another expert for a quote to use in the story. At this point, because the reporter knows the issue and the stakes, he or she will be expecting you to be able to represent a particular point of view. The reporter might be correct in this assessment, or not. It is up to you, the media advocate, to treat the interview strategically. It is also up to you to do your best to link any question to the solution you are seeking, as determined by your overall strategy. Do not expect reporters to do this for you. In this way, an interview is not a conversation, although it may feel like one. Instead, it is a series of opportunities to relay your definition of the problem, what needs to be done about it, and why it matters.

Particularly when you are talking to a TV reporter, but even with print and other electronic reporters, be concise. Answer the question with a link to your solution, and if you must say more, repeat what you just said. Reporters will often respond with silence to keep their interviewee talking; do not fall into that trap. Stay focused, concise, simple, and clear.

Talking with journalists

- A reporter is not your friend or enemy, but a professional trying to do his/her job.
- An interview is not a conversation.
- Consider everything you say to be on the record or don't say it.
- Know your opposition's arguments as well as your own.
- Never compromise your credibility.
- Keep your statements short
- Stay focused on your subject
- Keep stressing the policy solution
- Avoid jargon and slang
- Use relevant facts if you can
- It's OK to say, "I don't know."

25 Media advocacy examples

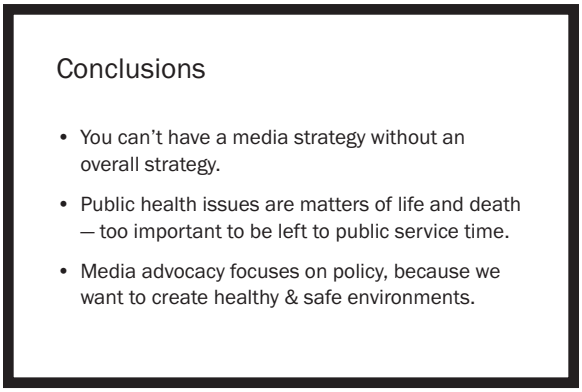
Media advocacy began in the 1980s in tobacco control, when public health advocates married the science of public health with the political tactics being used successfully by consumer advocates, such as Ralph Nader. Since then, media advocacy — as practiced in public health — has been applied to a variety of issues, from childhood lead poisoning, to violence prevention, to affordable housing, (just to name a few). In each instance of its application, the principles and practices of media advocacy are reinterpreted and reapplied to accommodate the particular settings and circumstances of the issue at hand.

26 Conclusions

Media advocacy is in service to community organizing and policy advocacy; it does not stand on its own. That is why you cannot have a media strategy without an overall strategy. You must know what you want, why you want it, and how you are going to get it, all *before* going to the media. In this way, media advocacy can amplify and accelerate policy advocacy.

Media advocacy is important, because it is one of the few public health interventions that focus upstream to change the environment in which people make health decisions. Public health matters are too important to be left to strategies that are at the mercy of television producers who have other priorities. That is one reason why, in public health, we can not depend on public service advertising, for example.

The focus on policy is critical because usually, although not always, it is the mechanism with which we can improve health environments — and therefore also health outcomes — for the broadest population. It is also where we can improve health environments for those populations who suffer most from premature death, preventable illness, and injury.



discussion questions

A General questions on media advocacy:

- Why is communication important for public health?
- What kinds of approaches are used?
- What is media advocacy?
- How is media advocacy different from other communication approaches?
- How does media advocacy relate to the basic question of public health?
- What are the basic elements of media advocacy?
- What is the prime directive, and why is it so important?
- What is a media strategy, and how do you develop one?

B Questions on news, framing, and reframing:

- What is news?
- What are the functions of the news media in our society?
- How do journalists decide which stories to cover?
- What do public health advocates have that journalists need?
- What is framing?
- Why is framing important?
- What is the difference between "episodic" and "thematic" frames?
- What are public health frames?
- What is the difference between "framing for access" and "framing for content"?
- How do you reframe an issue?

C Questions on general strategies and tactics:

- How do you monitor the media, and why is doing so necessary?
- How do you develop a press list?
- What makes something newsworthy?
- What is the process for creating news?
- What is the process for piggybacking on existing news?
- What is the role of paid advertising in media advocacy?
- What is an editorial strategy, and how do you develop one?

- How can the ethnic press be used for advocacy?
- What is a media bite, and how do you create one?
- How do you develop visuals?
- What are some examples of media bites, social math, and good visuals?

D Questions about interacting with reporters, editors, and producers:

- How do you talk to journalists?
- What questions must you ask to guide your interaction with journalists?
- What is the cardinal rule when talking with a journalist?
- What is the best way to pitch a story?
- How do you shape news stories to increase the likelihood of coverage?
- How do you do a good interview?
- What is the difference between a good conversation and a good interview?
- When do you say no to an interview?
- What are the major pitfalls of interviews, and how can they be avoided?
- How do you answer the really difficult questions?

E Questions for summary and review:

- What are the key lessons from the first generation of media advocacy efforts?
- What is the future for media advocacy in social change?

skills-building exercises

Newspaper analysis

Bring several copies of different newspapers to class. In small groups, students work to identify basic components of the paper (masthead, byline, dateline, op-ed, column, news and feature articles, etc.). Ask students to compare the front pages of the various papers and discuss the similarities and differences. Each group should then choose one story to analyze in-depth, based on questions such as: who are the characters in the story? What is the action or plot? What is the scene, and where does it take place? Does the scenario, or do the characters, presuppose certain outcomes or understandings? What are they? What interpretations are missing? Are there shorthand symbolic prototypes in the story, such as heroes, villains, victims, or scapegoats? What pictures does the story bring to mind? Is there a reasonable connection to public health for this story? What might it be? If you were going to respond to this article with a letter to the editor, and you wanted to highlight public health, what would you say?

Strategy development

Create brief scenarios based on students' areas of interest and/or the case studies in this report. In small groups, ask students to work through the following questions: can you describe your policy goal in plain language? If you get news attention, what will it accomplish? Who is your target? Who are you trying to reach by generating media attention? What is your media access strategy? What will you do to get reporters' attention, and who will do it? How will you frame the issue to advance your goal? How will you talk about your issue in the media? Finally, ask students to come up with three or four media bites that summarize their positions.

Creating media bites

A media bite is a concise response to a reporter's question. The important thing to remember when developing media bites is to keep focused on the policy goal. In this exercise, students will list possible questions to expect from a reporter on their issues, while also creating examples of how the same reporter's question might be answered differently depending on what they, the advocates, ultimately want to achieve. Ask students to work through the following questions: what are two or three different policy solutions to the problem you are working on? What is your favored solution or policy objective? What general questions might a reporter ask if s/he found out about the problem but did not know very much about it? What would you say in response to the first question so that your answer included your favored policy solution? What would you say in response to the same question so that your answer included a different policy solution?

assignments

1 Monitoring the news
Students are expected to read and/or view the news outlets of their choice, daily, throughout the course.

2 Framing analysis
Students will prepare a memo, no longer than five double-spaced pages, describing how a specific public health policy issue has been portrayed in the news. Students may choose to analyze one news source, or several. The purpose of the memo is to provide an overview of how supporters and opponents of specific topics are structuring their arguments in the news.

3 Social math worksheet
Students will research and write a one-page list of at least six different examples of social math. Each fact must be documented appropriately.

4 Letters to the editor
Students will prepare and submit to the news outlets of their choice two 100-250 word letters to the editor in response to news on the public health policy issue of their choosing. Students will turn in their letters, along with the piece in the news to which they are responding.

5 Op-ed
Each student will prepare a 600-750 word opinion piece on the public health policy issue of his or her choosing, and submit that piece to a print outlet to consider for publication. In lieu of an op-ed for a print publication, students may submit a commentary for a radio news program.

6 News release and media advisory
Students will prepare a news release and media advisory for a hypothetical event, in order to create news on the issue of their choice.

7 Media advocacy plan

Students will prepare a 12-15-page report, plus appendices, detailing a complete media advocacy plan on the issue of their choice. The plan must include: 1) an introduction explaining the purpose of the plan and any relevant background; 2) a problem overview and policy analysis, including an explanation of what is wrong, possible solutions, why the policy should be pursued, and the basic steps for enacting the policy, including the target(s), how they will be reached, and what action they should take; 3) an analysis of how the issue appears in the news, implications for the proposed policy, and how the issue needs to be reframed; and 4) the details of the media advocacy plan, including goals, objectives, overall strategy, target(s), message(s), access strategy, how it will be carried out, and evaluation (Note: this section will comprise the majority of the report). In an appendix, students should include materials for media advocates (e.g., FAQs, how to respond to reporters, etc.), as well as media kit samples (e.g., sample news release, sample media advisory, fact sheet(s), sample op-eds, and sample letters to the editor).

possible guest speakers

- Editorial writers and op-ed page editors.
- Media advocates who have worked under pressure, both on small and large campaigns.
- Legislative staffers for elected officials. Ask how they use media coverage, and how it influences the policy process.

required reading

Dorfman L, Wallack L, and Woodruff K. More than a message: Framing public health advocacy to change corporate practices. *Health Education and Behavior*, 32(4):320-336. 2005.

Dorfman, L. Using Media Advocacy to Influence Policy. In RJ Bensley and J Brookins-Fisher (Eds.), *Community Health Education Methods: A Practitioner's Guide* (2nd edition; Chapter 15). Jones and Bartlett Publishers: Sudbury, MA. 2003.

Institute of Medicine. *The Future of the Public's Health in the 21st Century* (Chapter 7). National Academies Press: Washington DC. 2003.

Wallack L, Woodruff K, Dorfman L, and Diaz, I. *News for a Change: An Advocates' Guide to Working With the Media*. Sage Publications: Thousand Oaks, CA. 1999.

suggested reading

Bagdikian BH. *The New Media Monopoly* (Foreword, Preface, and Chapters 1, 2 and 6). Beacon Press: Boston, MA. 2004.

Ryan C. *Prime Time Activism*, South End Press: Boston, MA. 1991.

Chapman S, and Lupton, D. *The Fight for Public Health: Principles and Practice of Media Advocacy*. BMJ Publishing Group: London. 1994.

Tye L. *The Father of Spin: Edward L. Bernays and the Birth of Public Relations*. Crown Publishers, Inc.: New York. 1998.

Wallack L, Dorfman L, Jernigan D, and Themba M. *Media Advocacy and Public Health: Power for Prevention*. Sage Publications: Newbury Park, CA. 1993

Case ctudies in media advocacy

Chapman S. Case studies in public health media advocacy. In S Chapman and D Lupton, *The Fight for Public Health: Principles and Practice of Media Advocacy* (Chapter 4). BMJ Publishing Group: London. 1994.

Dorfman L, Ervice J, and Woodruff, K. *Voices for Change: A Taxonomy of Public Communications Campaigns and Their Evaluation Challenges*. Paper prepared for the Communications Consortium Media Center, Washington DC, November, 2002. Download from http://www.mediaevaluationproject.org/

DeJong W. MADD Massachusetts Versus Senator Burke: A Media Advocacy Case Study. *Health Education Quarterly*, 23(3): 318.329. 1996.

Harwood EM, Witson JC, Fan DP, and Wagenaar AC. Media advocacy and underage drinking policies: A study of Louisiana news media from 1994 through 2003. *Health Promotion Practice* 6(3),246-257. 2005.

Jernigan D, and Wright P (Eds.). *Making News, Changing Policy: Case Studies of Media Advocacy on Alcohol and Tobacco Issues*. Center for Substance Abuse Prevention. USDHHS: Washington, DC. 1994.

Montgomery K. *Target: Prime Time, Advocacy Groups and the Struggle over Entertainment Television*. Oxford University Press: New York. 1989.

Rice R, and Atkin C. (Eds.). *Public Communication Campaigns* (3rd Edition),. Sage Publications, Inc.: Newbury Park, CA. 2000.

Salmon CT., Post LA, and Christensen, R.E. *Mobilizing Public Will for Social Change*. Paper prepared for the Communications Consortium Media Center, Washington DC, June 2003.

Seevak, A. *Issue 3: Oakland Shows the Way*. Berkeley Media Studies Group: Berkeley, CA. 1997. Download at http://www.bmsg.org/content/17.php

Woodruff, K. Alcohol advertising and violence against women: A media advocacy case study. *Health Education Quarterly*, 23(3):330-345. 1996.

other resources

Media advocacy websites

Action Media
http://www.actionmedia.org/

Berkeley Media Studies Group
http://www.bmsg.org/

Communications Consortium Media Center
http://www.ccmc.org/main.htm

Fenton Communications
http://www.fenton.com/

FrameWorks Institute
http://www.frameworksinstitute.org/

The Praxis Project
http://www.thepraxisproject.org

Public Media Center
http://www.publicmediacenter.org/

SmartMeme
http://www.smartmeme.com

The Spin Project
http://www.spinproject.org/

Selected news, media watchdog, and journalism tool websites

AlterNet
http://www.alternet.org/

Center for Media and Democracy
http://www.prwatch.org

CyberJournalist Super Search
http://www.cyberjournalist.net/supersearch.php

Fairness and Accuracy in Reporting
http://www.fair.org

Grade the News
http://www.gradethenews.org

Investigative Reporters and Editors
http://www.ire.org/

National Priorities Project Database
http://database.nationalpriorities.org/
also see The Cost of War http://www.costofwar.com/

NewsLab
http://www.newslab.org/

News University (Poynter)
http://discover.newsu.org/

Rough and Tumble
http://www.rtumble.com/

9

Evaluating Advocacy

introduction

Advocacy to influence public policy and reform systems has the potential to achieve large-scale results for individuals, families, and communities. Consequently, evaluation investments to ensure that advocacy is as effective as possible can help achieve the kinds of comprehensive and lasting changes that advocates seek. Positioned to inform where advocacy strategies are making progress and where mid-course corrections might be needed, evaluation can be an important ingredient in the policy and systems change process. It is important for advocates to ask themselves when starting their work: What questions do we want to be able to answer at the end of this effort?

Despite the benefits of evaluation, advocacy has long been considered "too hard to measure" and therefore few advocates have taken it on. Recently, however, this field has grown substantially, and advocates are now embracing evaluation as a critical part of their work. As interest has grown, enterprising evaluators and funders have begun to innovate in this area, developing guiding principles and practical tools that are helping to push the field forward and ground it in useful frameworks and a common language.

Starting from the premise that evaluation is a useful endeavor for advocates, this lesson brings these recent developments to bear and covers two main topics about evaluating advocacy:

How evaluating advocacy is unique. To date, the evaluation discipline as a whole has focused largely on evaluating programs that deliver direct services (e.g., programs to deliver health care services). As a result, much less is known about evaluating efforts like advocacy that venture beyond this more traditional program evaluation realm. While all evaluation shares some things in common, to be as useful as possible, advocacy evaluations need to adjust to the important differences between advocacy and other types of programs or services. This lesson discusses these key differences and their implications for evaluation.

The steps involved in planning an advocacy evaluation. This lesson recognizes that students in this course may never have to design an advocacy evaluation on their own, or even design one from start to finish. Even if advocates end up collecting evaluation data themselves, professional evaluators often assist during the planning process. It is important, however, for students to understand what goes into designing an evaluation. The lesson introduces the steps involved and shows students how to think about, and be active participants in, evaluation planning.

learning objectives

By the end of this lesson and completion of all assignments, students will be able to:

1. Explain the value of incorporating advocacy into evaluation efforts
2. Describe how evaluating advocacy is different from the more traditional evaluation of programs or direct services
3. Articulate the steps involved in advocacy evaluation planning
4. Participate in decision-making about advocacy evaluation, and make informed and strategic decisions in support of such efforts

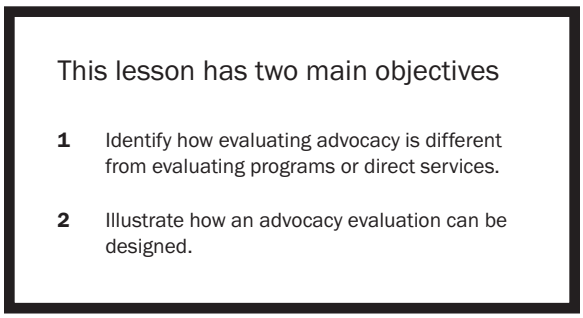
key points to be made in lesson

[Instructor:

Two handouts also are provided at the end of the lesson: 1) The Advocacy and Policy Change Logic Model, and 2) Advocacy and Policy Change Logic Model Definitions.]

1 Essential questions

This lesson will start with the question that comes up most often around this topic: Is there anything different about evaluating advocacy as compared to evaluating any other kind of effort, such as programs or direct services? This lesson will explore some of the norms that are emerging around evaluating advocacy. This lesson will also examine the steps and decisions involved in designing an advocacy evaluation, using a case study based on a hypothetical advocacy effort.

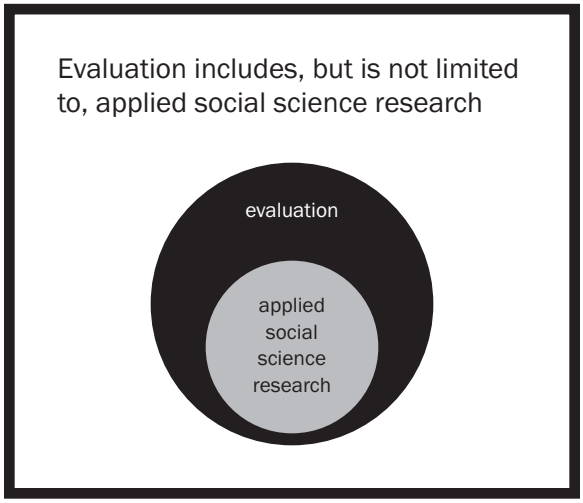


2 Evaluation includes, but is not limited to, applied social science research

Before getting to the specifics of how advocacy evaluation is unique, we begin with some discussion about how evaluation differs from applied social science research.

Evaluation uses social science research methods to determine the merit, worth, or value of things, usually social programs or direct services. The purpose of evaluation typically is to learn about a program's progress, or to make judgments about its effectiveness.

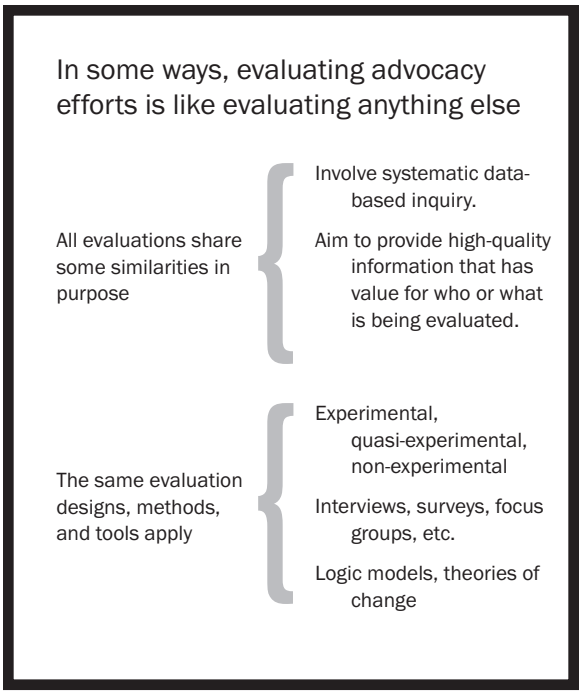
Although evaluation involves empirical investigation using social science techniques, evaluation also identifies the values or standards relevant to what is being evaluated, and then uses those standards with the empirical findings to make conclusions. For example, both evaluation and research of a program to immunize children would measure the number of children actually immunized. Research would simply report that number; evaluation would judge whether that number was high enough.



3 In some ways, evaluating advocacy efforts is like evaluating anything else

Consider how evaluating advocacy is different from evaluating programs; in so doing, also consider what is *not* different:

- All evaluations share some similarities in purpose. There are universal evaluation principles that apply to advocacy evaluation. For example, all evaluators conduct systematic and data-based inquiries to provide high-quality information that has significance or value for who or what they are evaluating. While evaluators have choices in the kinds of data they produce and how they position those data for use, those choices are similar across evaluations. Evaluation can be used to inform strategy and decision-making, build the capacity of evaluation stakeholders, or catalyze programmatic or societal change.
- In addition, evaluations can draw on the same designs, methods, and tools. Some may "fit" advocacy efforts better than others, but all evaluations can involve quantitative or qualitative data collection and draw on a similar set of research methods, such as interviews and surveys. Tools such as logic models or theories of change can be helpful in most, if not all, evaluations.



4 In other ways, evaluating advocacy is different and can be more challenging

Also consider what *is* different about evaluating advocacy. This requires us to think about how advocacy work differs from programs or direct services.

- *Strategies evolve.* The most important difference is that advocacy strategy typically evolves over time, and activities and desired outcomes can shift quickly. Most program evaluation designs prefer static conditions, and aim to keep the intervention from changing over time.
- *Advocates need real-time data.* Advocates also regularly adapt their strategies in response to changing variables and conditions. To make informed decisions, they need timely or real-time answers to the strategic questions they regularly face. Traditional program evaluations typically are not designed to provide feedback quickly; many only report at the evaluation's conclusion.
- *Contextual factors weigh heavily.* The policy process, itself, is also unique. While programs can be affected by unpredicted and contextual variables, the policy process takes that possibility to a whole new level. It is not possible to control for extraneous variables with advocacy. Program evaluation typically likes to control for that external "noise," when possible.
- *Many factors contribute to policy outcomes.* A single advocacy organization is not likely to be the only one working on a specific policy outcome. Other organizations are likely to be working for or against that same outcome, simultaneously. Consequently, if a policy outcome is achieved, it is difficult to isolate the role that a specific organization played.

In other ways, evaluating advocacy efforts is different and can be more challenging

Strategies evolve; activities can shift quickly.	>	Traditional evaluation designs prefer static conditions.
Advocates need real-time data.	>	Data needs must be collected and analyzed quickly.
Contextual factors weigh in heavily.	>	It is hard to control for extraneous variables.
Many factors contribute to policy outcomes.	>	It is hard to isolate a strategy's unique contribution.

5 Advocacy evaluation norms are emerging in light of these challenges

Because of these differences, advocacy has long been considered by many in the field as "too hard to measure." Lately, however, this field has begun to grow and many are now tackling advocacy's hard-to-measure distinctions. As a result, some "norms" are starting to emerge regarding the kinds of evaluation that make the most sense in this context.

- *Integrate evaluation.* While some evaluators try to stay removed from what they are evaluating in order to remain as objective as possible, with advocacy evaluation it is useful for evaluators to be more connected to the advocacy effort. This helps evaluators stay on top of any strategy changes, and to facilitate the kind of real-time reporting and feedback that advocates find useful.
- *Examine contribution, not attribution.* Advocates may be one of many factors that affect policy outcomes. It is more important to sort out and build a credible and defensible case about advocates' *contributions* to the policy process than it is to try to prove that they definitively *caused* a policy outcome.
- *Value interim outcomes.* It is important to assess advocacy for more than just its ultimate impact on policy. While policy change is usually the end goal, other outcomes related to the broader advocacy strategy, such as whether new advocates emerge, can be as important as the policy change itself.

Advocacy evaluation norms are emerging in light of these challenges

Integrate evaluation.	>	Evaluation tends to be most beneficial when it is integrated into advocacy strategies.
Examine contribution not attribution.	>	Demonstrating contribution to policy change is more important than proving attribution.
Value interim outcomes.	>	The end goal—policy change—is not the only important outcome to measure.
Define rigor broadly.	>	Rigor means methodological clarity, not just using experimental designs.
Realize that less can be more.	>	Advocates' capacity for evaluation must be taken into account.

- *Define rigor broadly.* All evaluations need to be methodologically rigorous. Rigor applied to advocacy means being clear about the evaluation's outcomes, methodology, and measures. Rigor does not *only* mean using experimental designs that use control groups or conditions. In fact, these designs typically are not feasible with advocacy efforts. The evaluation's rigor should match the evaluation question being asked; moreover, methodological rigor should, to some degree, match the advocacy effort's rigor. For example, sophisticated analyses of more "modest" advocacy efforts may not be the best use of resources; they can easily overwhelm initiative efforts with reporting and documentation requirements. Under these circumstances a "less is more approach" is wise when identifying both what to evaluate, and how.
- *Involve community stakeholders in the evaluation process.* Participatory evaluation involves working with community and stakeholder-group representatives to develop the evaluation plan, conduct the evaluation, and disseminate results. This kind of collaborative process has also been called empowerment evaluation. Advocates may also help stakeholders increase their capacity to evaluate their own programs.

6 A hypothetical case study illustrates the evaluation planning process

Now let's talk about the second and main objective of this lesson—*how* to actually design an advocacy evaluation. The following "case study," based on a hypothetical advocacy effort, provides the backdrop for a "walk" through the evaluation planning process:

Case study: Advocacy for universal health care coverage

In this example, the organization leading the advocacy effort is a statewide health advocacy organization aiming for the policy outcome of universal health care coverage. The organization would like the state to have a policy similar to the one enacted in Massachusetts that requires all residents to purchase health insurance or face penalties. Health insurance choices would be expanded to include a range of new and inexpensive options provided by state-subsidized private insurers. The advocacy organization has drafted a policy proposal that lays out their plans, and now is trying to get either the governor or legislature to take leadership on it.

The organization has a great deal of capacity for traditional advocacy. Staff regularly do policy analysis and research, educate state legislators in one-on-one meetings, work with the media, testify in hearings as experts, etc. But they have had a hard time moving the universal health care coverage issue using these traditional means. They have concluded that this issue calls for a targeted grassroots strategy in specific communities around the state, featuring local coalitions advocating, and demonstrating community-based demand, for universal health care coverage.

This organization previously has not done community organizing, but is committed to achieving universal health care coverage. Staff want to see whether they can build their capacity to include community organizing and then use that capacity in support of other issues. To give their work on-the-ground legs, they have decided to partner with local community organizations in key districts throughout the state in order to help organize and lead the local coalitions that will do outreach to state-level policymakers. If the strategy is successful, the expectation is that policymakers will see the demand for policy change coming from their local constituents and be more inspired to act.

7 Three kinds of decisions are involved in designing evaluations

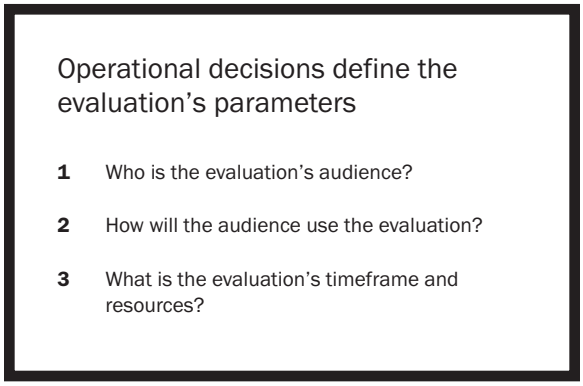
One of the most common mistakes we make in evaluation is to jump right to the task of figuring out the evaluation methodology. This skips a number of important steps that should come first in the design process — steps that help make sure that the evaluation is as strategic and focused as possible, and that it delivers the right kind of information when it is needed.

Three kinds of decisions are involved in designing an evaluation: utilization, strategic, and methodological. These decisions should be made in order, as one set of decisions influences the next. This will be exemplified using the hypothetical case study example.

8 Utilization decisions define evaluation parameters

The first decisions about an evaluation are about how it will be used. These decisions provide the lenses through which all other evaluation decisions should be viewed.

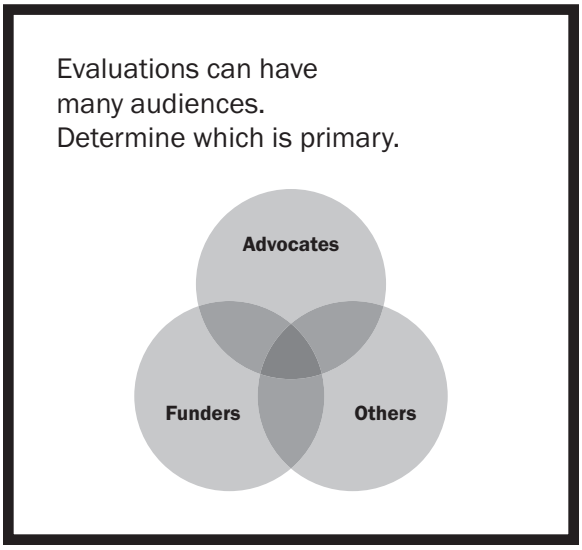
The questions here are about the evaluation's audience, how the audience will use the evaluation, and the evaluation's timeframe and resources. (Note: The importance of making upfront decisions about audience and use is consistent with an evaluation approach called *utilization-focused evaluation,* developed by renowned evaluator Michael Quinn Patton.)



9 Evaluations can have many audiences. Determine which is primary.

Advocacy evaluations can have many audiences. The most common audiences are the advocates themselves or the advocacy effort's funders. If there is more than one audience, all audiences' needs should be considered and balanced. However, it is important to define which audience is *primary,* as there are times when all audiences' needs cannot be met at once.

Once the audiences, and primary audience, have been identified, the evaluation generally should use a participatory approach and involve audience members in helping to develop the evaluation design (see Lesson 5 on participatory research). Gaining clarity upfront regarding what the audience wants can help avoid misplaced expectations down the road.

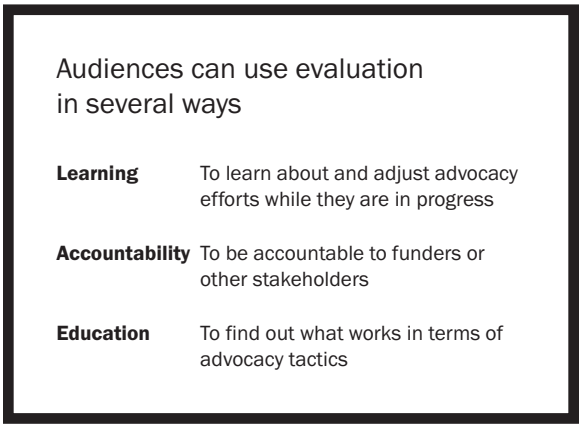


Case study: Audience

In the hypothetical case study, the advocacy organization is the main evaluation audience.

10 Audiences can use evaluation in two main ways

Next, it is important to determine how the audience intends to use the evaluation. Ways of using evaluation generally fall into two categories: learning and accountability.



- *Learning* is related to advocates' need for real-time data that can inform ongoing strategies. As progress data are reported, advocates can use those data to learn what is working well and what midcourse corrections may be needed.
- *Accountability* means that the evaluation is used to hold advocates responsible for doing what they said they would do. Advocates can be accountable to their funders, themselves, their collaborators, and to the public.
- *Education* means using evaluation to find out which advocacy strategies or tactics are effective, so that those approaches can be used again. The challenge here is that the policy process can be so volatile, and involve so many variables, that what works in one policy context may not work in another.

Case study: Evaluation uses

The evaluation's audience, the statewide health advocacy organization, plans to use the evaluation for learning. Because this is their first experience organizing a grassroots effort, they are interested in using the evaluation to learn both how they are doing and how they might improve their approach along the way. Also, they want to know if organizing is something they want to do long-term.

11 The evaluation's timeframe and resources help set expectations

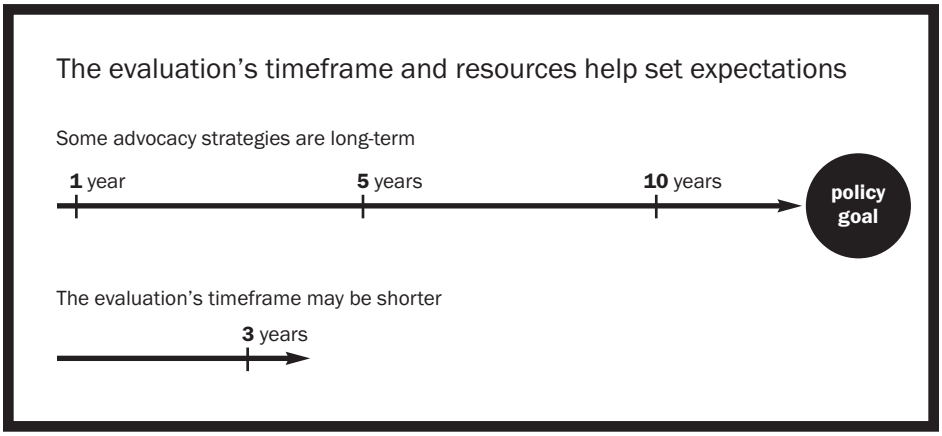
Most advocacy efforts are not short-term. Policy goals take numerous years to accomplish. Evaluations, however, may take place on a shorter timeline.

The point here is to make sure that the evaluation has realistic expectations about what advocates and the evaluation can accomplish within the available timeframe. For example, measuring some outcomes too early can unfairly make it look like advocates have failed.

Resources are also important. Funding for advocacy efforts may range from the tens of thousands to millions of dollars. Expectations about what results advocacy efforts will produce should be adjusted, accordingly. Similarly, advocacy funding directly affects the resources available for evaluation. Generally, it is wise to conduct an evaluability assessment that assesses the proposed evaluation's likely benefits against the cost and level of effort it creates.

Case study: Timeframe and resources

The strategy for achieving universal health care coverage is a five-year investment, but the strategy's evaluation is slated for its first two years. About $75,000 per year is available for the evaluation.



12 Strategic decisions focus the evaluation

The next set of decisions is labeled *strategic* because these decisions are affected by the aforementioned fact that there are often limited resources for evaluation. It is rarely possible or useful to measure *everything* about an advocacy effort. These questions help to focus the evaluation on what it is most strategic to measure.

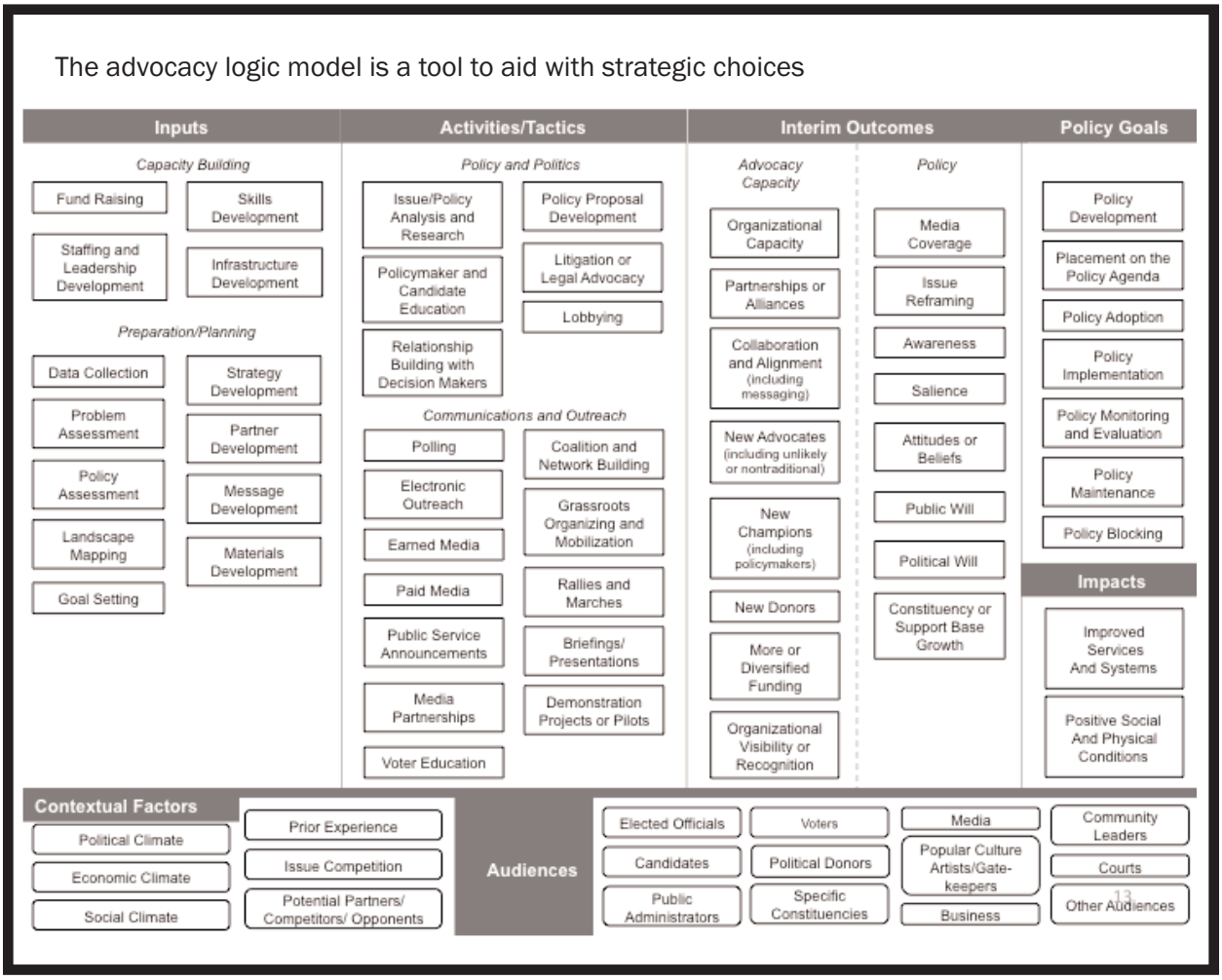
Strategic decisions focus the evaluation

1. What is the advocacy strategy?
2. Given the evaluation's audience and use, which outcomes are most important?
3. Are there outcomes the strategy should not be directly accountable for?
4. Given the evaluation's timeframe, which outcomes are achievable?
5. Given the evaluation resources available, which outcomes are priorities?

13 The advocacy logic model is a tool to aid with strategic decisions

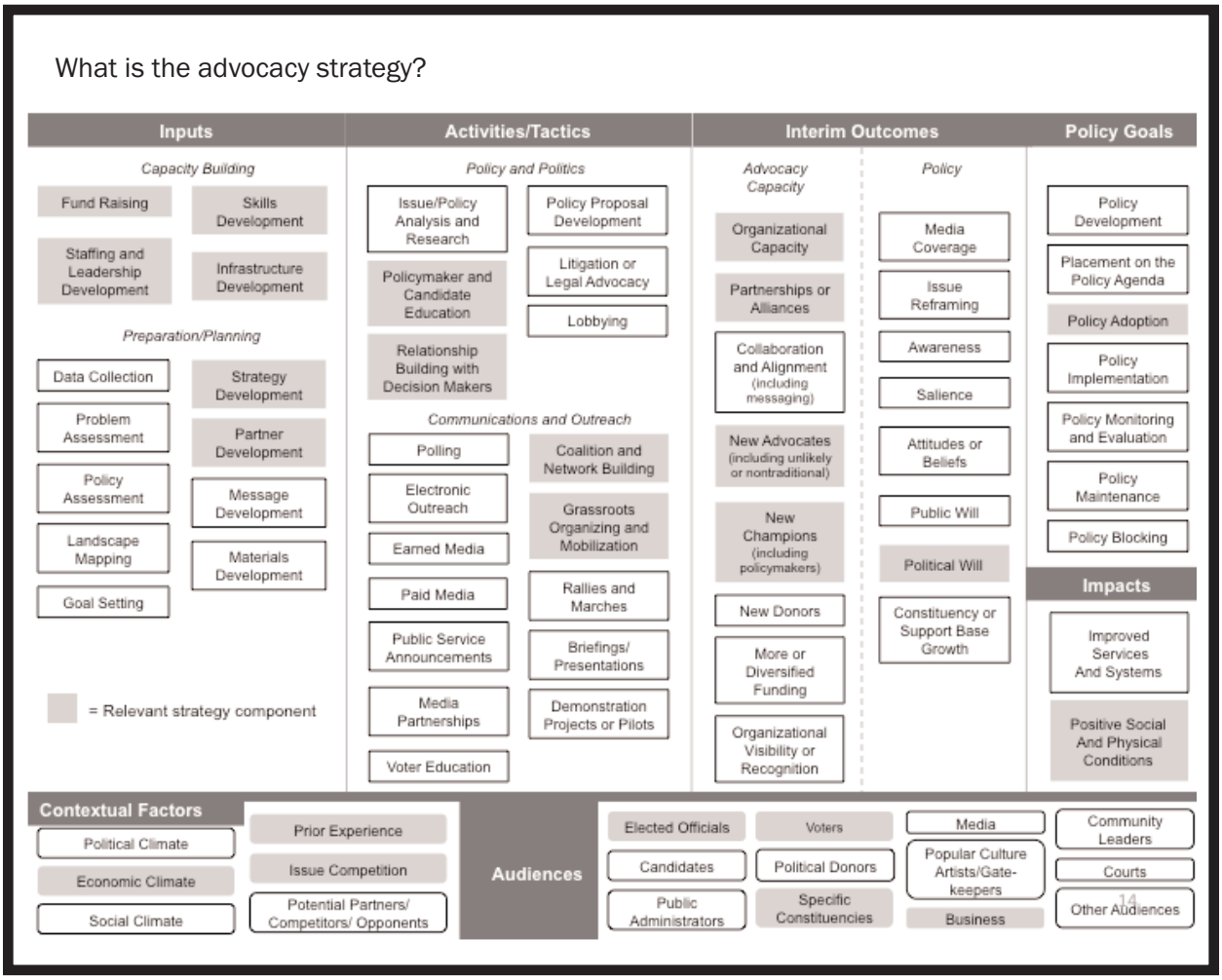
The "advocacy logic model" was developed to help guide strategic advocacy evaluation decisions. This model is designed to help illustrate the main parts of any advocacy strategy. It shows the "full" range of inputs, activities, outcomes, and impacts that may be part of an advocacy strategy. More than 50 experts in advocacy, policy change efforts, and evaluation helped to develop this model.

The next five slides use this model to walk through five questions that facilitate strategic choices about an advocacy evaluation's focus.



14 What is the advocacy strategy?

Begin by selecting the components in the composite logic model that are relevant to the advocacy strategy being evaluated. Literally trace "a pathway" through the logic model, selecting relevant *inputs*, *activities*, *interim outcomes*, *policy outcomes*, and *impacts*. Select also the strategy's *audiences*, as well as the *contextual factors* that might impact the strategy.



Case study: Strategy

As the logic model's shading shows, the hypothetical advocacy strategy's *policy goal* is the adoption of new universal health care legislation (a policy proposal already has been developed; the task is to get a bill introduced and passed). The universal health care policy's ultimate *impact* will be improvements in health outcomes across the state.

The advocacy strategy will need to target several *audiences*. First, it will be important to engage audiences to participate in the local coalitions. These audiences include voters, health care providers (a specific constituency), and the em-

ployers or business community. Second, it will be important to engage elected officials, including the governor and state legislators, who have the authority to make policy change happen.

There is also shading of the advocacy strategy's remaining components (i.e., the inputs, activities, and interim outcomes) needed to achieve the universal health care policy goal. Because the organization has not done this kind of work previously, upfront capacity is needed in terms of *inputs* in the areas of funding, staffing, infrastructure, and skills. Additionally, the organization needs a grassroots strategy and local partners across the state, in order to build and lead the coalitions.

Activities will include coalition building and grassroots organizing, followed by the mobilization of coalition members to do targeted outreach to policymakers and other key decision makers through briefings and presentations and relationship building, in general. *Interim outcomes* fall into three main categories. The first is whether sufficient advocacy capacity has been built for successful grassroots mobilization on universal health care. The second is whether people are actually being recruited to, and participating in, the advocacy effort. Finally, the third is whether organizing builds the political will necessary for the policy to be adopted.

15 Given *audience* and *use*, which outcomes are most important?

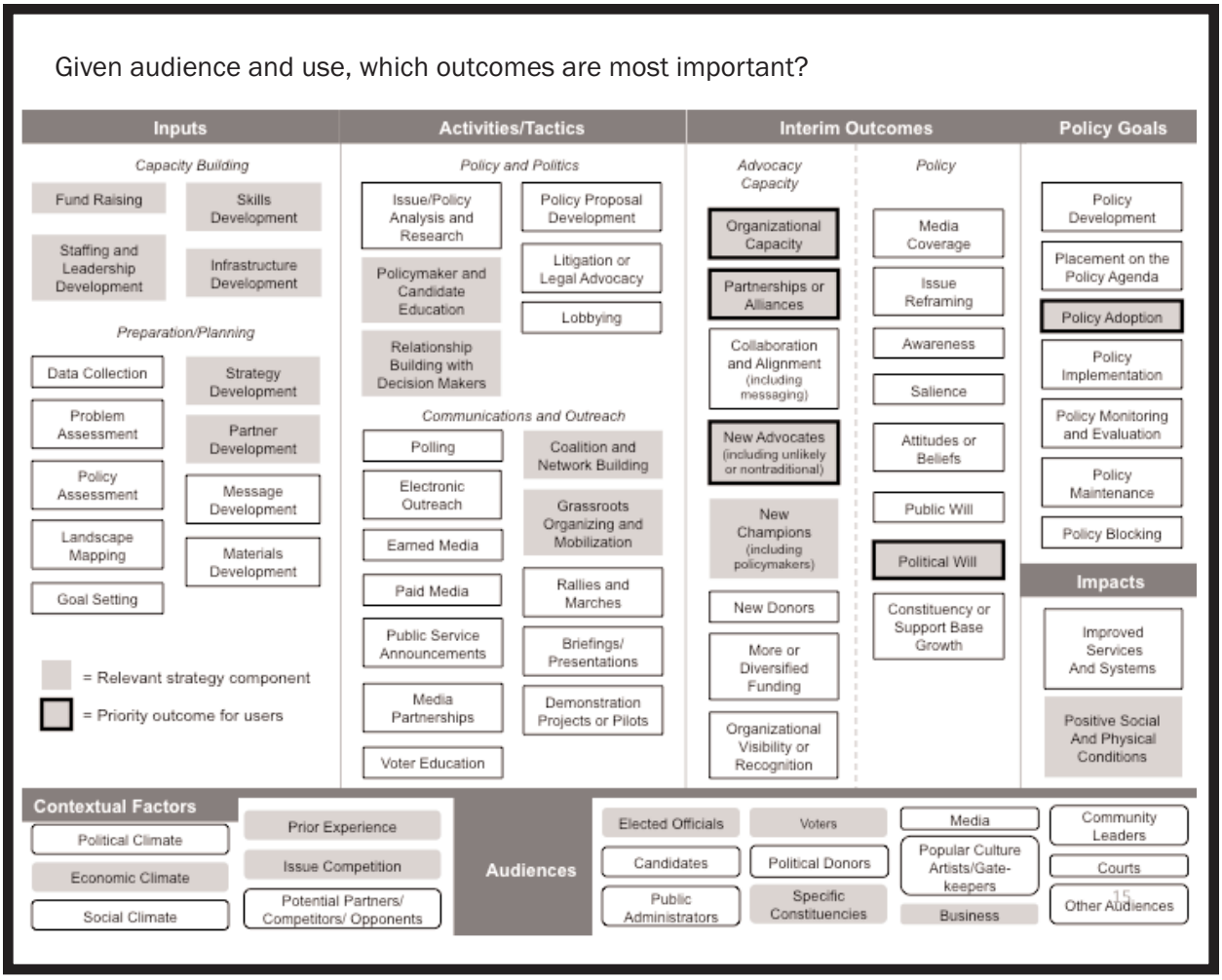
While the evaluation could focus on all of the logic model components that are connected to the advocacy strategy, various factors — including the evaluation's audience and how they intend to use it, the evaluation timeframe, and available evaluation resources — may call for a strategic narrowing of the evaluation's focus. The remaining questions concentrate on how to use the logic model to help make those decisions.

First, consider the evaluation's audience, what it wants or needs to know about the strategy's progress or success, and how the information will be used. Given these decisions, are some strategy components more important to assess than others? For example, if the primary audience is the organization leading the advocacy effort, and that organization wants to use the evaluation to get real-time data that will suggest opportunities for continuous strategy improvement, then the evaluation may want to focus on assessing the activities and interim outcomes that come earlier in the policy change process. A funder, on the other hand, may be more interested in learning about the strategy's ultimate success in achieving its policy outcome(s) (e.g., moving the issue higher on the policy agenda or ensuring that a policy is properly implemented).

Case study: Evaluation users and use

Again, the evaluation's main user is the advocacy organization, itself. Staff are concerned with whether the organization can successfully adopt a new grassroots approach. As a result, they are interested in getting feedback on the interim outcomes that are outlined with bold lines in the model. Specifically, the

organization wants to know whether it has developed sufficient *grassroots capacity,* both within the organization and at the local level; whether they have chosen the right *local partners*; and whether the *local coalitions* they are trying to launch or activate are actually operational and recruiting new advocates. The organization is also interested in whether *political will* is starting to grow in the state, as this is critical to whether they will reach their policy goal.

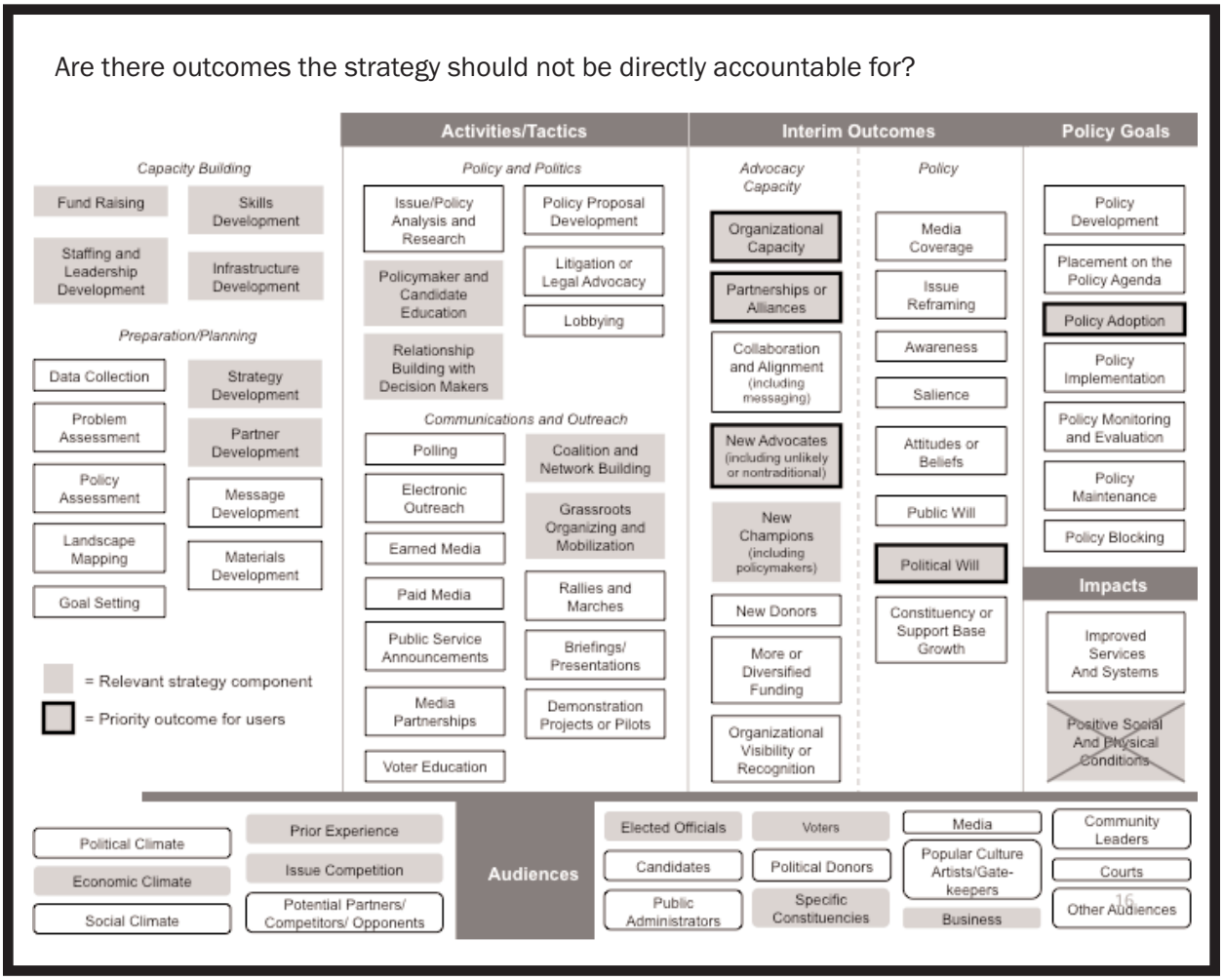


16 Are there outcomes for which the strategy should *not* be directly accountable?

For some advocacy and policy change efforts, certain outcomes or impacts related to the advocacy strategy may be so long-term, or hinge on so many external or contextual factors, that it is appropriate to focus the evaluation more on the shorter-term or interim outcomes that are directly connected to the advocacy effort.

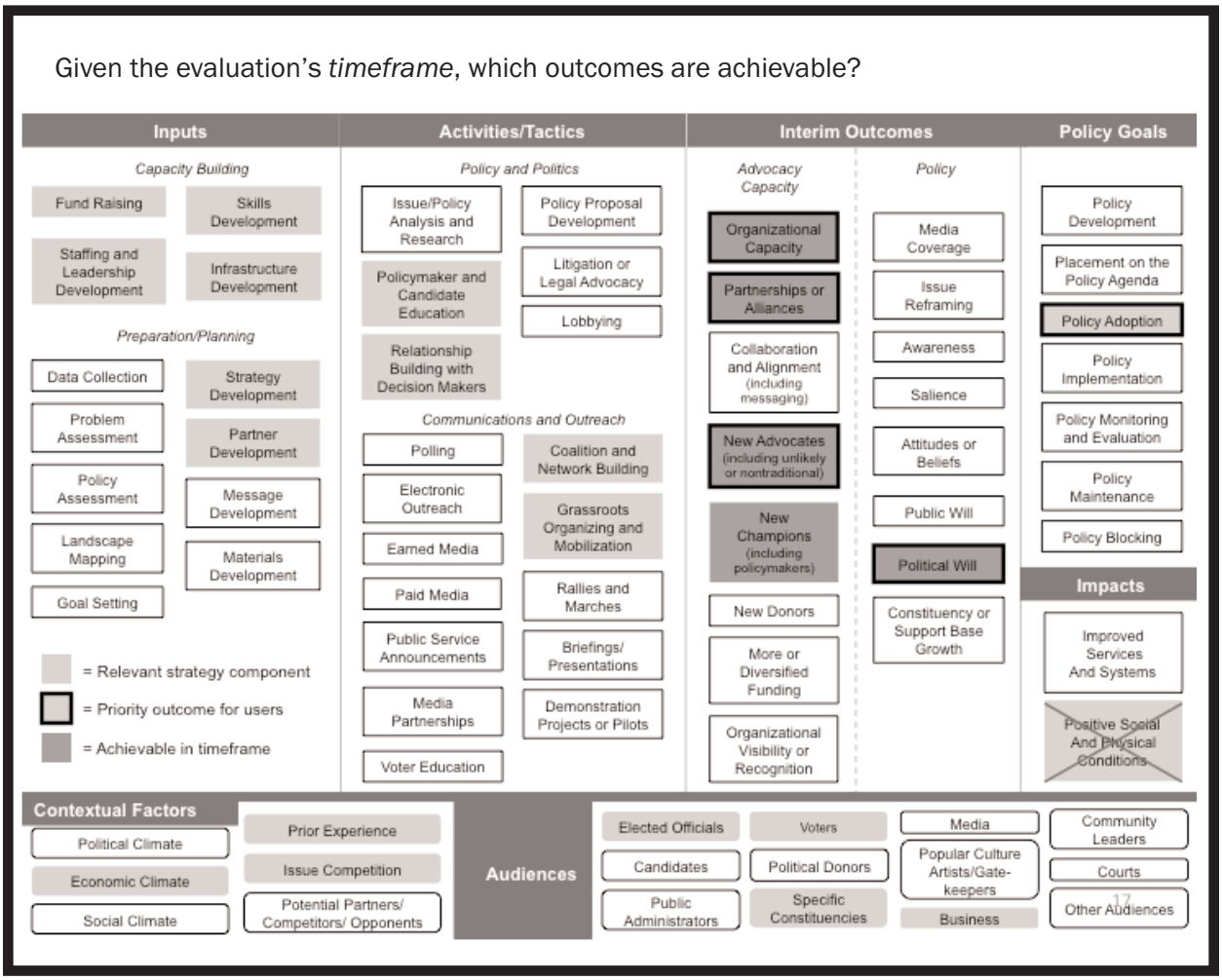
Case study: Components on which the evaluation should not focus

This slide crosses out the component on the model on which the evaluation will not focus: the *long-term impacts* of a universal health care coverage policy. Ultimately, the advocacy strategy is about getting a universal health care policy adopted. The impacts relate to the strategy's long-term vision and help to "make a case" for the policy, but because they will only play out if the strategy successfully achieves its policy outcome, it would be premature to measure those factors before that outcome occurs.



17 Given the evaluation's *timeframe*, which outcomes are achievable?

As mentioned earlier, often advocacy strategies are long-term endeavors with evaluations that run on shorter timeframes than the strategies themselves. For example, an organization with a ten-year advocacy strategy might have a three-year evaluation because the strategy's funder would like to make decisions about whether to continue funding, or because the advocacy organization wants to understand early whether it is gaining traction on the way to its policy goal. Consider what outcomes among those selected in the logic model are realistic to expect within the evaluation's timeframe.



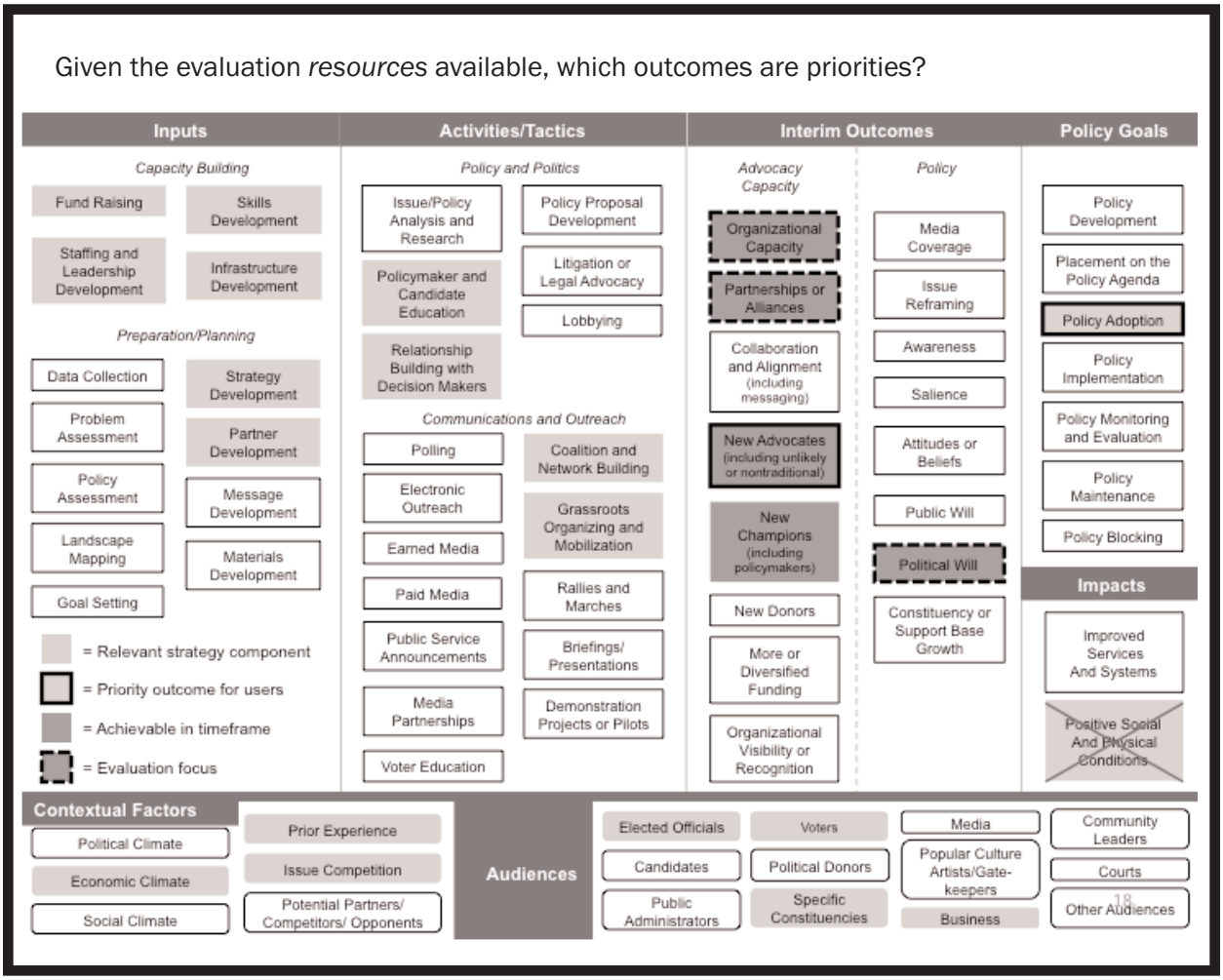
Case study: Achievable outcomes within the evaluation's timeframe

In this example, the strategy is a five-year investment, but the strategy's evaluation is slated for its first two years. Within those two years, the advocacy organization expects to see real progress on the interim outcomes that are shaded darker in the model. Specifically, the organization expects its *capacity for grassroots* work to be built and for *local coalitions* to be functional. If after two years these outcomes have not been achieved, the organization will reconsider its strategy.

18 Given the evaluation resources available, which outcomes are priorities?

Rarely are enough evaluation resources available to collect data on every relevant strategy component. If resources are limited, where might they most strategically be focused? Where are learning needs, or accountability demands, the greatest?

Consider also whether the evaluation will be internal or external. Some outcomes may be well-suited for internal monitoring and tracking, rather than external evaluation. Other outcomes may be better suited to the expertise or objective perspective that an external evaluator can bring, such as in assessing advocates' influence on key audiences in the policy process (e.g., policymakers, the media, the business community, or voters).

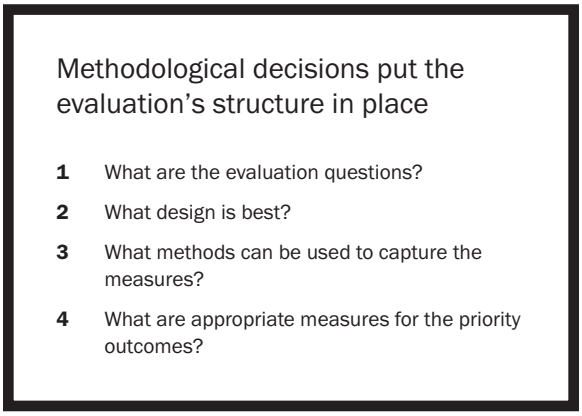


Case study: Evaluation resources

The advocacy organization has limited resources for the two-year evaluation. As such, among the outcomes the organization thinks are achievable within two years, it wants to focus on three that are initial priorities: the development of *organizational capacity* for grassroots work, effective *local partnerships* or alliances, and *political will*. The first two outcomes can be monitored internally; the third will require outside evaluation expertise.

19 Methodological decisions put the evaluation's structure in place

Now that priorities have been established, it is time to finish the evaluation planning process by making decisions about methodology. Four questions apply here. The first is about the evaluation questions, themselves. The second is about the evaluation's overall design. The third is about methods. The fourth is about the measures, also often referred to as indicators, metrics, or benchmarks.

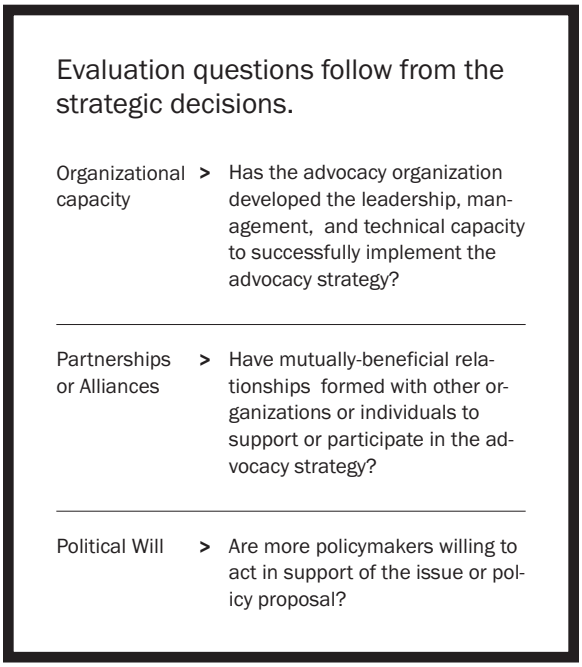


20 Evaluation questions follow from the strategic decisions

Once all of the strategic decisions have been made, it should be clear where the evaluation will focus; evaluation questions should then flow from those decisions. For example, did paid media generate issue awareness within the target audience? Did specific outreach tactics increase the number of individuals who signed on to be a part of local coalitions?

Case study: Evaluation questions

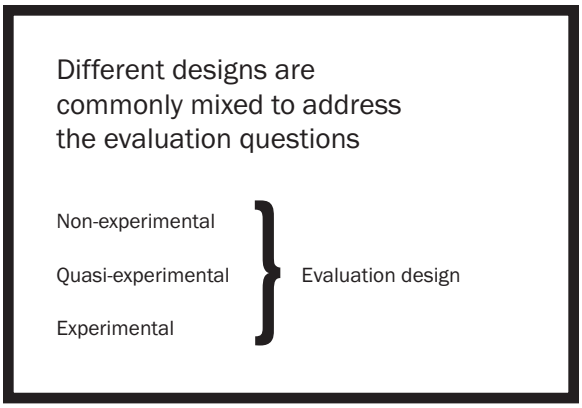
This slide shows the three interim outcomes identified earlier as priorities for the evaluation. The evaluation questions are designed to examine whether those outcomes are in place.



21 Different designs are commonly mixed to address the evaluation questions

Evaluations feature three main types of designs — experimental, quasi-experimental, and non-experimental. With advocacy efforts, experiments are rarely, if ever, used; quasi-experiments are more common; non-experimental designs are the most common. Some advocacy evaluations feature both quasi-experimental and non-experimental elements, as sometimes different questions call for different designs.

The dominance of non-experimental designs generally raises questions about whether advocacy evaluations are methodologically rigorous. Rigor applied to advocacy evaluation should not *only* mean using experimental designs that use control groups or conditions. Rigor is more appropriately defined here as achieving clarity and consensus about the evaluation's outcomes, methodology, and indicators, and the ways in which the evaluation will ensure it produces credible and defensible findings (e.g., using triangulation of methods or evidence).



Case study: Evaluation design

The first evaluation question about changes in organizational capacity can be addressed with a quasi-experimental pre-post design. The second evaluation question about partnerships or alliances can be addressed with a non-experimental case study design. The third evaluation question about political will also can be addressed with a quasi-experimental pre-post design.

22 Methods can be both traditional and innovative

Like all evaluations, advocacy evaluations can draw from the familiar list of traditional evaluation methods, which includes surveys, interviews, focus groups, polling, etc. The field has also developed some new methods specifically pertaining to advocacy. These include:

- *Bellwether methodology:* Determines where an issue is positioned in the policy agenda queue, how lawmakers are thinking and talking about it, and how likely they are to act on it. The methodology involves structured interviews with "bellwethers," or influential people in the public and private sectors whose positions require that they are politically informed and track a broad range of policy issues.
- *Social-network analysis*: Explores whether connections or relationships exist, as well as their nature and strength. It identifies the "nodes" (i.e., people, groups, or institutions) that make up the network or system, and then examines the relationships between them using mathematical algorithms.
- *Blog tracking*: Like media tracking, uses blog search engines to track whether issues or proposals are generating "buzz" in the blogosphere.
- *Policymaker ratings*: Gauges policymaker support for particular issues or proposals by rating them on scales that include their relative levels of support for the issue, as well as their political influence.
- *Intense period debriefs*: Engages advocates in evaluative inquiry, shortly after a policy window or intense period of action occurs.

Case study: Methods

The first evaluation question about changes in organizational capacity can be addressed through surveys or an advocacy capacity assessment. The second evaluation question about partnerships or alliances can be addressed with surveys, interviews, or possibly a social network analysis. The third evaluation about political will can be addressed with the bellwether methodology.

Methods can be both traditional and innovative

Traditional	Public polling
	Media tracking
	Policy tracking
	Interviews
	Surveys
	Focus groups
	Observation
	Document review
Innovative	Advocacy capacity assessment
	Bellwether methodology
	Social network analysis
	Blog tracking
	Policymaker ratings
	Intense period debriefs

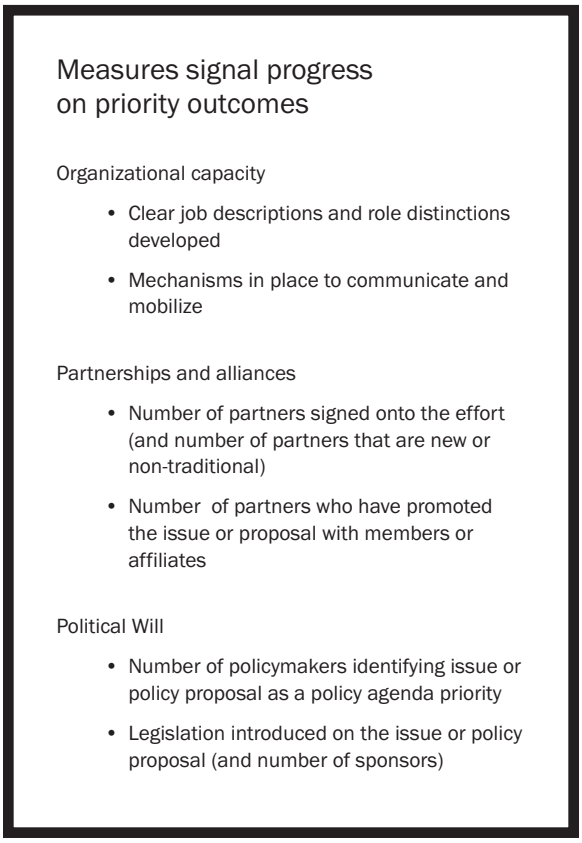
23 Measures signal progress on priority outcomes

The final step of evaluation planning is to develop the measures that the methods will capture. This step involves going back to the priority outcomes identified earlier and attaching measures to them. Keep the following guidelines in mind as measures are developed:

- *How well does the measure link to an outcome?* Measures should, to the extent possible, capture effects and provide the most direct evidence of the outcome(s) they are measuring.
- *Are data currently being collected?* If not, is cost effectiveness data collection an option? Where data are not currently collected, the cost of additional data collection must be weighed against the potential utility of the additional data.
- *Is the measure important to most people?* Will it provide sufficient information to convince both supporters and skeptics? Measures must provide information that both will be easily understood and accepted by the evaluation's audience.
- *Is the measure quantitative?* Numeric indicators often provide the most useful and understandable information. In some cases, however, qualitative information may be necessary and more appropriate.

Case Study: Measures

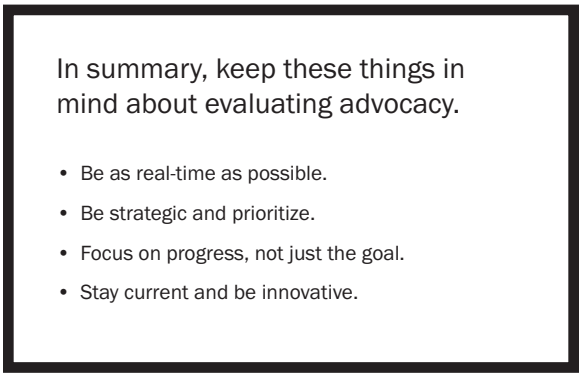
This slide provides example measures for the three priority outcomes. These measures will be captured using the methods identified on the last slide.



24 In summary, keep these things in mind when evaluating advocacy

Key points about advocacy evaluation include:

- *Be as real-time as possible.* Advocacy strategy evolves without a predictable script. Evaluation is most useful when it is positioned to regularly inform strategy.
- *Be focused and prioritize.* Advocates have limited resources for evaluation. Be strategic about what gets evaluated. Do not be afraid to leave some parts of the strategy "off the table."
- *Focus on progress (i.e., interim outcomes), not just the policy goal.* The ultimate goal of most advocacy work — policy change — is typically easy to measure. It is the process of achieving policy outcomes that is more challenging to assess, and where most advocacy evaluations need to focus.
- *Stay current and be innovative.* Advocacy tactics are constantly changing and evolving. Evaluation needs to keep pace. Evaluators also should not be afraid to be methodologically creative. Measurement within a policy context is a unique endeavor, and the field is in need of new ways of assessing hard-to-measure outcomes, such as public or political will.



discussion questions

A A basic premise of advocacy evaluation is that it is often most beneficial when it is integrated into the advocacy effort so it can adapt with, and inform, the advocacy strategy as it also evolves. In some cases, the evaluator might even be considered a member of the advocacy team. This approach is different from conventional research norms that advise the researcher to remain completely separate from the advocacy effort in order to remain objective and avoid bias. What are the advantages and disadvantages of having an evaluator that is integrated into the advocacy effort? Is there a point at which an evaluator might "cross the line" in terms of his or her role? Are there ways that "embedded" evaluators can manage potential bias?

B Because evaluation resources often are limited, or because advocates do not want to be overburdened by evaluation, sometimes it is important to choose what aspects of an advocacy strategy do and do not get evaluated. What criteria should be used in making those decisions? Under what conditions is it acceptable to say that a part of the strategy should *not* be evaluated?

skills-building exercises

In-class exercise #1

Split students into two groups. Assign one group to be the "community organizing group," and the other to be the "media advocacy group." Have the groups consider the two questions, below, for a total of 20 minutes. Afterward, have each group take four minutes, each, to report back with their responses.

1 Imagine that you have decided to use [community organizing or media advocacy] as part of your advocacy strategy. What kinds of data might you want to collect to help you determine whether your [community organizing or media advocacy] efforts are making progress or are successful?

2 What methods might you use to collect the data you have selected?

In-class exercise #2

Consider the following scenario: For the last year, a nationwide advocacy campaign has been in place to raise awareness among Americans about both the major health obstacles faced by young children in developing countries, and about the millions of needless deaths worldwide that can be prevented if basic inexpensive interventions are provided (e.g., vaccines, insecticide-treated netting, rehydration). In addition to raising awareness about this problem and its potential solutions, the campaign aims to spur Americans to act on behalf of the 10 million children under the age of five

who die each year from preventable diseases. The campaign has defined "acting" as sharing campaign messages with friends, colleagues, or family members; donating dollars that can be used to purchase and deliver child health interventions in developing countries; and speaking out to elected officials about policies and investments that can help to address this global crisis. The campaign's ultimate goal is to demonstrate to elected officials that Americans care about this issue and want the kinds of policy changes that will make a difference in terms of child survival.

The campaign has a number of core strategy components. For example, taking a page from Al Gore and his *Inconvenient Truth* effort, it has enlisted a high-profile celebrity spokesperson, produced a documentary on child survival featuring this celebrity, and developed media partnerships to ensure the documentary will be aired on national television. The campaign also has an extensive e-advocacy strategy with a website, pages on Facebook and MySpace, and advertising partnerships with Google, Amazon, and AOL.

In addition to its media strategy, the campaign has a "ground strategy" organized around partnerships with Schools of Public Health across the country. Knowing that students tend to be particularly enthusiastic about global issues, the campaign has employed public health graduate students to become organizers on child survival issues in their local communities. Students sponsor local events to raise awareness of child survival, and to help to facilitate community action.

One year in, however, the campaign is discouraged. The number of donations is low and not meeting expectations. While people are going to the campaign website, they are not staying for long, nor taking action once they get there. Hardly anyone is directly speaking out to public officials. And, while some student-led organizing efforts have really taken off, many have now begun to stall.

Advocates running the campaign want to use evaluation to help them determine where and why their strategy is not working. For the next 25 minutes, students should discuss the following and be prepared to report back to the larger group:

1 Hypothesize 3-5 possible reasons for the campaign's lackluster results. Feel free to be creative and fill in missing details; there is no right or wrong answer.

2 Of the 3-5 possible reasons identified, pick the one you think is most important to explore through evaluation. Be prepared to defend your choice.

3 Identify how you might collect data to determine if the reason you identified is, in fact, contributing to the problem. Remember that time is important; the strategy needs to be fixed as quickly as possible. Therefore, data collection should be "rapid response" in nature.

assignments

Hand out the four-page advocacy evaluation scenario on childhood obesity, located at the end of this lesson. Both of the assignments, below, are based on this scenario.

1 Limited resources

You have limited evaluation resources of only $20,000 a year. With those resources you know you will not be able to evaluate all parts of the advocacy strategy. Write a one- or two-page paper describing on which aspects you think the evaluation should focus. Use the logic model as a tool to guide your thinking. Consider the two evaluation audiences and what each wants from the evaluation. Note that there is no right or wrong answer; the point is to make a decision and explain your justification for it. Be sure to identify potential disadvantages to the choices you have made. Feel free to be creative and fill in any missing details that will inform your decision.

2 Outcomes

Look at the shaded boxes in the logic model's "Interim Outcomes" column. Seven outcomes are shaded as relevant to the advocacy strategy on childhood obesity. These are:

- Partnerships or alliances
- New advocates
- New champions
- Media coverage
- Issue reframing
- Political will
- Constituency or support base growth

Choose two of these outcomes to address. For each of the outcomes selected, identify 1) why it is important to track that outcome; 2) at least three possible measures to capture progress or success on that outcome; and 3) how you would collect data on those measures.

For example, if the choice was media coverage, a possible measure might be the number of newspaper articles featuring the terms "childhood obesity" and "epidemic" in the same article, as the advocacy effort wants to convey the problem's seriousness. The method for capturing that measure might be a monthly electronic search of all the major daily newspapers in the state to determine whether there are any increases in frequency of the media's framing of childhood obesity as an epidemic.

possible guest speakers

- **Advocate who has used evaluation to inform advocacy efforts:** Ask the advocate to speak about why s/he made the decision to evaluate advocacy efforts, how decisions were made about which approach(es) to use, and most importantly, how evaluation data were used.
- **Evaluator who has evaluated advocacy and can speak to the approach(es) used:** Ask the evaluator to speak about the challenges s/he encountered in developing the evaluation, as well as how those challenges were overcome. Have the evaluator discuss the different methods used to collect data, how often data were reported, and how those data were used.
- **Advocate and evaluator, together:** Ask them to speak about how they combined their efforts to create a useful evaluation. Ask about the challenges and benefits of working as a team, and whether, in hindsight, they might have made different evaluation choices given what they now know.
- **Expert on a specific advocacy evaluation methodology:** for example, someone with expertise in public polling, social-network analysis, or media tracking. Ask the expert to talk about when the methodology should, or should not, be used; how it works; and examples of the kinds of findings that approach can deliver.

required reading

Guthrie K, Louie J, and Foster CC. *The Challenge of Assessing Policy and Advocacy Activities: Strategies for a Prospective Evaluation Approach*. Blueprint Research and Design and The California Endowment: Los Angeles, CA. 2005. [Available at www.calendow.org.]

Harvard Family Research Project. Advocacy and policy change. *The Evaluation Exchange*, 8(1):1-32. Cambridge, MA. 2007. [Available at www.hfrp.org.]

Patton MQ. Evaluation for the way we work. *The Nonprofit Quarterly,* 13(1): 28-33. 2006.

suggested reading

Kingdon JW. *Agendas, Alternatives, and Public Policies* (2nd ed.). Longman: New York. 1995.

On evaluation, in general

Fetterman D and Wandersman A. *Empowerment Evaluation Principles in Practice.* Guilford Press: New York. 2004.

Harvard Family Research Project. The Evaluation Exchange. 1995-present. [Subscribe for free or access issue archives at www.hfrp.org]

Patton MQ. *Utilization-Focused Evaluation: The New Century Text*. Sage Publications Thousand Oaks, CA. 1997.

Weiss C. *Evaluation* (2nd ed.). Prentice Hall: Upper Saddle River, NM. 1998.

W.K. Kellogg Foundation. *The W.K. Foundation Evaluation Handbook*. Author: Battle Creek, MI. 1998. [Available at www.wkkf.org]

On advocacy evaluation

Guthrie K, Louie J, and Crystal Foster C. *The Challenge of Assessing Policy and Advocacy Activities: Part II—Moving from Theory to Practice*. Blueprint Research and Design and The California Endowment: Los Angeles, CA. 2006. [Available at www.calendow.org]

Reisman J, Geinapp A, and Stachowiak S. *A guide to measuring advocacy and policy.* Organizational Research Services for The Annie E. Casey Foundation: Baltimore, MD. 2007. [Available at www.organizationalresearch.com]

Reisman J, Geinapp A and Stachowiak S. *A handbook of data collection tools: Companion to "A guide to measuring advocacy and policy."* Organizational Research Services for The Annie E. Casey Foundation: Baltimore, MD. (2007).
[Available at www.organizationalresearch.com]

On advocacy evaluation methodologies

Bagnell SJ. Necessity leads to innovative evaluation approach and practice. *The Evaluation Exchange*, 13(1):10-11. 2007. [Available at www.hfrp.org]

Belden, Russonello, and Stewart. "Using survey research to evaluate communications campaigns." Media Evaluation Project. Communications Consortium Media Center: Washington, DC. 2004. [Available at www.mediaevaluationproject.org]

Blair E. Evaluating an issue's position on the policy agenda: The bellwether methodology. *The Evaluation Exchange*, 13(1):29. 2007. [Available at www.hfrp.org]

Douglas Gould and Company. "Writing a Media Analysis." Prepared for the Communications Consortium Media Center. 2004. [Available at www.mediaevaluationproject.org]

Durland M, and Fredericks K (Eds.). *New Directions for Evaluation: Social Network Analysis in Program Evaluation* (Vol. 107). Jossey-Bass: New York, NY. 2005.

Smith B, Matheson K, and DiJulio S. *eNonprofit Benchmarks Study: Measuring Email Messaging, Online Fundraising, and Internet Advocacy Metrics for Nonprofit Organizations.* M+R Strategic Services and the Advocacy Institute: Washington, DC. 2006. [Available at www.e-benchmarksstudy.com]

TCC Group. "The Advocacy Core Capacity Assessment Tool." 2007. [This is an addendum tool to TCC Group's Core Capacity Assessment Tool (CCAT), available at www.tccccat.com, which presents an assessment of a nonprofit organization's organizational capacity. The Advocacy CCAT builds on the broader CCAT by incorporating key organizational effectiveness measures that are unique or particularly important for policy and advocacy organizations.]

other resources

Advocacy Evaluation Online Clearinghouse (www.innonet.org)
The Innovation Network's online clearinghouse has a wide array of annotated resources on evaluating advocacy efforts, including reports, articles, tools, and frameworks. Many resources are drawn from other notable organizations also engaged in advocacy evaluation. New resources are added regularly. Materials are categorized by primary audience (i.e., funder, evaluator, or practitioner), region (i.e., domestic versus international), and by topic (e.g., general advocacy evaluation, network evaluation, communication evaluation).

Americans for Nonsmokers' Rights (www.no-smoke.org)
This organization has lobbied for policy and legislation to protect nonsmokers from exposure to secondhand smoke and prevent tobacco addiction among youth. The organization's website provides data and resources for advocates, including a chronology of the advocacy work that eventually achieved smokefree transportation.

Advocacy Evaluation Update Newsletter (www.innonet.org)
Innovation Network's free e-newsletter focuses on the challenges of evaluating policy advocacy initiatives. It is helping to build the advocacy evaluation field and conversation through articles, interviews with practitioners, resources, and references.

Advocacy Progress Planner (www.planningcontinuousprogress.org)
This new online tool is an interactive online version of the same advocacy logic model featured in the PowerPoint accompaniment to this lesson. Users can create their own logic models, shading the parts of the model that relate specifically to their advocacy effort. It was developed by Continuous Progress Strategic Services, in collaboration with Julia Coffman.

Continuous Progress (www.continuousprogress.org)
This online guide for funders and advocates provides a step-by-step roadmap for planning advocacy efforts and conducting evaluations before, during, and after implementation. Continuous Progress has two separate editions, one on global or foreign policy advocacy, and the other on domestic policy advocacy. It was developed by The Global Interdependence Initiative and Continuous Progress Strategic Services, in collaboration with Edith Asibey and Justin Van Fleet.

Student Handout: Advocacy Evaluation Scenario — Childhood Obesity

Problem:

The percentage of children considered obese in this country has tripled in the last thirty years. Because overweight children have about a 70 percent chance of becoming overweight adults, today's kids represent the first generation at risk of having shorter life spans than their parents. Consequently, finding effective programs and policies to prevent and treat the crisis of childhood obesity has grown into a national priority. It is particularly a crisis in your state, which ranks among the worst in the nation according to child obesity indicators.

Politics:

Recently, federal and state interest in tackling childhood obesity has grown. Your Governor was elected last year on a platform that included a strong commitment to improving children's health, but so far she has not made a firm policy or budgetary commitment on obesity. Her policy advisors have indicated a possible interest in a new initiative on this topic, but no details yet have been worked out.

Proposal:

You work for a nonprofit organization with a long-standing commitment to improving child health, including combating childhood obesity. You have worked on multiple programs aimed at both increasing kids' physical activity levels and improving nutrition, through parent- and school-based programs.

While you have had pockets of success with these direct service programs, you recognize that no single intervention or group acting alone can stop the childhood obesity epidemic. You are interested in more comprehensive and systemic solutions to this problem, and feel that such change can only be accomplished with a substantial state policy and funding commitment.

You have planned a major five-year advocacy effort to urge the state to make such a commitment. You understand that combating this problem requires a multipronged and comprehensive approach involving families, schools, communities, industry, and government. You want the state to put the infrastructure and funding in place to enable this kind of comprehensive effort.

Your policy goal is to get the state to establish a new statewide policy that sufficiently and sustainably funds comprehensive efforts to tackle childhood obesity. The policy would include:

- School nutritional standards for food and beverages served
- In-school and out-of-school programs designed to increase child activity levels and improve nutrition
- Parenting education
- Incentives for community design that encourages physical activity

Strategy:

You believe that several things are needed to convince policymakers that childhood obesity is an issue whose "time has come" in the policy arena. Your thinking is based on political scientist John Kingdon's 1995 theory of agenda setting.

According to Kingdon, agenda setting is the first stage in the policy process. Moving an idea onto that agenda involves three processes: problems, proposals, and politics. *Problems* refer to the process of persuading policymakers to pay attention to one problem over others, and can be influenced by how problems are defined or framed. *Politics* are political factors that influence agendas, such as changes in elected officials, political climate or mood, and the voices of advocacy or opposition groups. *Proposals* represents the process of getting a policy proposal on the "short list" of ideas being considered, which typically requires selling it as technically feasible, reasonable in cost, and appealing to the public. Successful agenda setting requires that these elements come together at a critical time — when a "policy window" opens. Policy windows can be created, and you, as an advocate, intend to create one.

Your plan proposes action in all three agenda-setting strands:

Problem: The public and policymakers are aware that childhood obesity is a problem, but they may not understand that childhood obesity is an *epidemic*. Further, they tend to assign parents the blame and responsibility for fixing it. Strategic communication strategies are needed to reframe understanding of who is responsible, and to emphasize potential upstream solutions. Advocacy activities will include:

- Media outreach to frame the problem as a family, school, community, industry, and government responsibility, and not just a parental responsibility
- Building public will both to educate the public and engage people on the issue

Politics: Getting policymakers to pay attention to this issue will require that the advocacy voice both be diversified and strengthened. This will require:

- Coalition building with nonprofits, schools, parents, pediatricians, business, and others, in order to unify advocacy voices and develop effective spokespersons

Proposal: Needing to develop a comprehensive but feasible policy proposal, and then outreaching to policymakers to build momentum. Activities will include:

- Policy development to research and outline details of a proposed state investment that includes multiple components: school nutritional standards, in-school and out-of-school programs, educating parents, and community incentives
- Policymaker outreach, both executive and legislative, about childhood obesity in the state and your proposed solutions for it.

Logic Model:

The logic model on the next page further defines the parts of the advocacy strategy described above.

Evaluation:

Evaluation is important to you and you have always done evaluation for the programs you implement. But this effort is different, and unlike your direct service programs, the evaluation will not be able to show you or your Board members how kids directly benefited from your investments. You are not sure how to approach the evaluation, and need to think carefully about your options.

Audiences and Uses:

Your experience has taught you about multiple evaluation designs and approaches, and you know that the best way to determine the most appropriate approach is to first identify the evaluation's audience and how they will use the evaluation. You see two potential audiences: your own organization, and your funders. Each would likely use the evaluation in different ways.

You are interested in data — particularly in the first two years — that will help you understand if your tactics are working and gaining momentum, as well as whether midcourse corrections are needed. At the same time, you are interested in an evaluation that is manageable and will not create a lot of extra work.

Your funders are interested in whether the advocacy effort made a difference in the public and policy arenas. They want to know how the public and policymakers responded to advocacy tactics, and of course, whether the policy goal was achieved. They understand that these results may not be available until later in the strategy, and that it is possible that the policy goal might not be achieved within the allotted five-year timeframe.

Timeframe:

The evaluation will take place during all five years of the advocacy strategy's implementation.

Resources:

Your advocacy strategy has been funded for $1 million: $200,000 per year, for five years. If you assume the evaluation budget should be about 10 percent of the overall investment (a generous assumption), that comes to about $20,000 a year for evaluation, or $100,000 total. Because this is a new type of strategy for you and you recognize its importance as a learning opportunity for your organization, you might be able to add more dollars for evaluation. Regardless, it will be important to think *strategically* about how to invest these limited evaluation dollars.

Childhood Obesity Advocacy Logic Model

Inputs

Capacity Building

- fund raising
- skills development
- staffing and leadership development
- infrastructure development

Preparation/Planning

- data collection
- strategy development
- problem assessment
- partner development
- policy assessment
- message development
- landscape mapping
- materials development
- goal setting

Activities/Tactics

Policy and Politics

- issue/policy analysis and research
- policy proposal development
- litigation or legal advocacy
- policymaker and candidate education
- lobbying
- relationship building with decision makers

Communications and Outreach

- polling
- coalition and network building
- electronic outreach
- grassroots organizing and mobilization
- earned media
- paid media
- rallies and marches
- public service announcements
- briefings/ presentations
- media partnerships
- demonstration projects or pilots
- voter education

Interim Outcomes

Advocacy Capacity

- organizational capacity
- partnerships or alliances
- collaboration and alignment (including messaging)
- new advocates (including unlikely or nontraditional)
- new champions (including policymakers)
- new donors
- more or diversified funding
- organizational visibility or recognition

Policy

- media coverage
- issue reframing
- awareness
- salience
- attitudes or beliefs
- public will
- political will
- constituency or support base growth

Policy Goals

- policy development
- placement on the policy agenda
- policy adoption
- policy implementation
- policy monitoring and evaluation
- policy maintenance
- policy blocking

Impacts

- **improved services and systems**
- **positive social and physical conditions**

Contextual Factors

- political climate
- prior experience
- economic climate
- issue competition
- social climate
- potential partners/ competitors/ opponents

Audiences

- elected officials
- voters
- media
- business
- courts
- candidates
- political donors
- popular culture artists/ gate-keepers
- community leaders
- other audiences
- public administrators
- specific constituencies

A

Vignettes and Lessons from Public Health Advocacy

Moving Targets

A story of a campaign to require Health Maintenance Organizations to provide language access services in California. Advocates learned the importance of working with multiple targets and policy-making bodies, over time, to achieve the desired goal.

Local People, Local Policy

A story of achieving a county-wide tobacco policy by mobilizing allies in 18 local jurisdictions. Advocates gained the support of local politicians by working through a wide range of personal and professional relationships.

Respectful Engagement

A story of one organization's decision to change their oppositional approach to advocacy in favor of long-term relationship building. Advocates learned that alienating key individuals in particular policy battles could hurt their long term social change goals, while building collaborations could facilitate their goals.

Strategic Steps

A story about Americans for Nonsmokers Rights' campaign to eliminate smoking on airlines. Advocates learned that choosing incremental steps wisely can set the stage for achieving ultimate policy goals.

Community Members as Powerful Advocates

A story of using Community Based Participatory Research to identify community priorities and build an environmental justice agenda. Advocates demonstrate that community wisdom is critical in a successful advocacy effort.

How You Can Do Everything Right and Still Lose…At Least at First

A story of the campaign to allow the sale of emergency contraception over-the-counter. Advocates learned how politics can impede science-based health policy making at federal agencies.

You Want Butter With That? Exposing Health Risks

A story of the media advocacy campaign by the Center for Science in the Public Interest to improve the nutritional value of popcorn sold at movie theaters nationwide. Advocates demonstrate that thinking like journalists is a critical step in ensuring your campaign gets covered.

Changing Targets, Changing Tactics

A story of the Dump Diesel Coalition's effort to reduce the use of diesel burning buses in San Francisco, California. Advocates learned how to develop new advocacy strategies and targets when their efforts for policy change stalled.

When Voluntary Business Policies Are Your Only Option

A story of the Campaign for Safe Cosmetics' effort to pressure multinational cosmetics companies to agree to reduce the toxic ingredients in their products. Advocates learned to combine hard hitting media tactics with community organizing efforts to achieve their goals.

Moving Targets

Ellen Wu, California Pan-Ethnic Health Network

Lesson:

Choose the right target for a policy change, and stay flexible as the target shifts throughout the policy change process.

Background

Patients with limited English proficiency face many barriers to quality medical care. When professional medical interpreters are not available, patients' family members or untrained bilingual staff are often asked to translate for patients. However, their command of both languages and medical vocabulary may not be sufficient, leading to inappropriate or delayed treatment.

In 1998, the Department of Health and Human Services' Office for Civil Rights declared that the denial or delay of medical care due to language barriers was a violation of Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of national origin. However, due to lack of adequate provider reimbursement and resources for enforcement, there is very little compliance. Left to the prerogative of business, managed care organizations have been reluctant to provide these services voluntarily. Advocacy groups realized that they needed regulations to require health insurers to provide these services.

The Story

In 2000, several advocacy groups — the California Pan-Ethnic Health Network (CPEHN), Center for Health Care Rights, Consumers Union, Health Access, Latino Issues Forum (LIF), and Western Center for Law and Poverty — formed the Managed Care Consumer Advocacy Collaborative (the Collaborative) to ensure effective consumer representation in the newly created California Department of Managed Health Care (DMHC). According to the 2000 Census, a majority (53%) of the population in California are people of color, and an estimated 40% of the population speak a language other than English at home. Advocates wanted DMHC to require health plans to provide culturally and linguistically appropriate services, and to collect data on the racial/ethnic composition and language needs of their members.

Target one: The regulatory body (administrative advocacy)

The Collaborative began working directly with DMHC through its regulatory process. Advocates were successful in adding language access requirements to new grievance regulations that outlined how health plans must collect and respond to complaints by members. However, after about a year, the DMHC determined that regulating cultural and linguistic services and requiring the collection of race, ethnicity, and language data was outside the scope of their regulatory authority. The Collaborative realized that they had to go to the state legislature to pass a new law to explicitly give DMHC the necessary authority.

Target two: The legislature (legislative advocacy)

The advocates' next step was to introduce legislation that would give DMHC the authority to regulate cultural and linguistic services of health plans. The bill's wording was deliberately kept simple, giving DMHC broad authority to create new regulations. The legislative co-sponsors trusted that their allies within the DMHC would create strong regulations once they had the explicit authority to do so.

Negotiations with industry stakeholders led to amendments that added details that health plans did not want left up to DMHC. The bill was passed by the legislature and signed by the governor in October 2003.

One month later, an unprecedented special recall election occurred in which Democratic Governor Gray Davis was replaced by Republican Arnold Schwarzenegger. With this change in the executive branch, many of the staff with whom the advocates had worked with for several years were replaced with new people less informed about the importance of cultural and linguistic services to quality care.

Back to target one: The regulatory body (administrative advocacy)

The passage of the bill was just the first step. Equally important in the advocacy process is making sure a bill is implemented as intended. Overcoming the gubernatorial recall and strong health plan opposition took five years of educating DMHC staff, applying pressure through public testimony, and raising awareness through media advocacy work. Through multiple drafts of the regulations, advocates and health plans waged battles on important issues, including the requirement for the collection of race/ethnicity data, and systems for notifying health plan enrollees of their new rights.

The full implementation of SB 853 on January 1, 2009 marked an historic landmark in the efforts to ensure access to culturally and linguistically appropriate care. For the new rules to be successful, consumer advocates' work must continue. Only by holding DMHC accountable for monitoring health plan compliance and informing communities of their new rights can advocates ensure that all Californians receive quality care in the language that they can understand.

Key Lesson

<u>It's not over even when it looks over</u>

As this story shows, advocates may celebrate their victory in passing a bill or adopting a new regulation, but creating real change may require several targets and victories in a row. It's important to track the evolution of your policy goal, identify new targets as necessary, and continue to work to be sure the ultimate goal is reached.

Local People, Local Policy

Larry Cohen, Prevention Institute

Lesson:

Advocates can be powerful at the local level because politicians' actions are more visible to their constituencies than they may be at the state or federal levels.

Background

In 1984 in Contra Costa County, California, the Board of Supervisors and all 18 City Councils in the county adopted uniform multi-city tobacco laws, becoming the first multi-jurisdictional region in the nation to do so. The legislation, restricting smoking in restaurants, workplaces, and public spaces, was a powerful victory against the tobacco industry and set the stage for other anti-smoking landmarks. The victory was achieved by galvanizing the active support of key constituents of local politicians in each city.

The Story

The local chapters of the three leading voluntary organizations — the American Cancer Society, American Heart Association and American Lung Association — had not historically collaborated with one another due to competition for donations. And when it came to prevention approaches, most of the organizations' notions of prevention were limited to information and education. However, they saw the need for a policy proposal to confront smoking, and they formed the Contra Costa County Smoking Education Coalition.

One of the first challenges they faced was the fact that a county-wide policy doesn't have standing within the boundaries of the cities in that county; each city must adopt their own policy. Contra Costa County had 18 separate cities, with many businesses operating in more than one. The Coalition agreed that without a consistent, multi-jurisdictional policy enforced countywide, consumers and business owners would have difficulty complying with the new smoking laws.

They began to strategize ways to build support for the initiative. The common friction between cities and counties over issues like property tax allocations was typified in Contra Costa. Further, most cities in the U.S. see health as under the purview of County government and do not have staff with responsibility for health. People involved with policy development in the county advised the Coalition that calls to City Council members and City Managers were not likely to be returned. Even calls from the directors of the Cancer, Heart and Lung associations might have been ignored, as such organizations have little influence on City government.

The Coalition set out in search of leverage, and found that they already had it within their coalition. Board members of the Cancer Society, the Heart Association and the Lung Association included influential and involved community members who in many cases also contributed to local politicians' campaigns. Doctors involved

in the Associations treated local politicians and their families, and knew other local politicians through social networks. By taking inventory of Board members, volunteers and their contacts, the Coalition widened its support network.

Rather than looking at cities as a whole, the Coalition looked at who on a city council would be most likely to sympathize with its legislation and approached that member first. Perhaps a city council member would ignore a call from the Coalition, but when she received a call from her number one contributor or her father's heart surgeon, she would return it. And when local media received op-ed pieces and letters to the editor written by local health practitioners — and could interview these practitioners — they were apt to print their ideas.

In addition, the Coalition identified the relevant skills and resources of each member organization. One was particularly adept at dealing with the media, another had strong ties to the business community, some were able to rally their memberships and volunteers to show up at cities and support the proposed legislation. As the initiative attracted attention the Coalition received offers of funds and for volunteers, and these were funneled to the three non-profits. In this way, they maximized their resources and quickly broadened their coalition to include business members, government officers and other influential members of the community who would have seemed like unlikely partners had they not fully appreciated the potential of their member organizations.

Media attention in the cities where legislation was proposed resulted in far more community education than might have been achieved through the use of brochures and also helped to perpetuate volunteer involvement. Coordinators dispersed volunteers to various cities. They recruited citizens to sign onto the legislation or attend their local city council meetings in support of it. Involved community members, including members of the business community who helped counteract the notion that tobacco legislation was anti business and would damage bottom line revenues, bolstered their argument. The Coalition was able to garner widespread support. Each city became an ad-hoc strategy group. Coalition participants in each city figured out what the most important elements were in order to garner support, and then marshaled those forces.

Such momentum did not go unnoticed by the tobacco industry. In fact, shortly after the Coalition's first meeting, the tobacco industry approached a Coalition leader through its lobbying arm, The Tobacco Institute. The institute's lead lobbyist for the state tried to persuade him over lunch that the coalition should use an educational, instead of a policy, approach. "They're not opposed to prevention," he said, "just prevention *policy*." This was evidence that the Coalition was on the right track. As they continued to pursue legislation, The Tobacco Institute opposed it in every jurisdiction, attempting to organize business owners against it, questioning the veracity of their concerns about secondhand smoke, and flying in experts from across the country for media appearances and testimony. The industry efforts to parry the Coalition failed.

Following the 1984 success, the local Cancer, Heart and Lung Associations brought the collaborative approach to each organization's national offices. Their national offices then joined with Americans for Non-Smokers' Rights to end smoking on airlines. Local coalitions prospered across the country, gradually upping their policy goals. In retrospect, it's clear that these ordinances had a ripple effect, leading to ever more smoking regulations by all levels of government; changing smoking norms; and ultimately, improving health.

Key Lessons

Politics is personal
Leverage local networks by having nonprofit board members and other influential community members directly contact the policy makers with whom they have personal connections.

Be prepared for opposition
When powerful anti-public health opposition organizes against your work, it may be a sign you're on the right track.

Put the ripple effect to work
Local jurisdictions can be fertile ground for innovative public health policies. As more local communities adopt a policy, it can build powerful momentum for broader changes at the state and federal levels.

[*Based on Larry Cohen's "Collaborating to Improve Community Health: Smoking Education Coalition Achieves a Multi-city Policy" case study.*]

The Story of the Marin Abused Women's Services' Advocacy Strategies

Donna Garske, Marin Abused Women's Services

Lesson:

Effective advocacy sometimes requires a light touch.

Background

Since 1977 Marin Abused Women's Services (MAWS) has worked to end violence against women by providing direct services and pursuing policy changes such as initiating judicial system reform and improving local law enforcement policies.

Early on, MAWS leaders adopted a "fight" model of advocacy, in keeping with the approach of powerful community organizers such as University of Chicago sociologist Saul Alinsky. On key policy issues, MAWS leaders identified their opposition and conducted direct action campaigns to publicly expose their opponents' actions, hold them accountable, and demand action. Eventually, however, MAWS discovered that this approach was sometimes counter-productive, as this story illustrates.

The Story

After one particularly brutal case of domestic violence occurred in their local community, MAWS organized a typical "fight" model response: they conducted a direct action campaign to publicly pressure officials in law enforcement agencies and the criminal justice system to prosecute the case to the full extent of the law. Rather than getting what they wanted from their direct action and letter writing campaign, however, MAWS alienated the very people they needed to persuade to achieve their goals. Their action so severely damaged their relationships with key individuals in the local criminal justice system that the advocates took a step back to examine what went wrong and why.

On reflection, MAWS realized that their advocacy model of "us against them" assumed that someone had to lose and didn't give their opponents enough opportunity to collaboratively find a solution. MAWS could win particular policy battles with this model, but it wouldn't build the local relationships they would need for lasting social change. To reduce violence against women on a local level, MAWS would need not only policy change but, for example, the long term cooperation of local law enforcement to refer clients to their direct services and counseling programs.

In response to this realization, MAWS developed a "respectful engagement" advocacy model, which prioritizes building relationships over time to create allies, not opponents. Rather than surprising officials with advocacy actions, MAWS tries to hammer out collaborative solutions. MAWS creates a memorandum of understanding (MOU) with each collaborator that outlines the responsibilities of each and

what will happen if there is an irreconcilable disagreement on an issue. This is MAWS' promise to deal with their collaborators directly, giving them advance notice of steps MAWS will take to represent their constituency, including those that involve public criticism. They are putting their belief in peace and nonviolence into practice with the way they approach their allies and the power holders with whom they work.

This model of being soft on the person, but hard on the problem, has shown results. Concerned about the low rate of emergency protective orders (EPO) being enforced by police, for example, MAWS considered a tactic in keeping with their old advocacy model — releasing a report to the media. Instead they approached local law enforcement officials directly about the problem. This led to a collaboration that offered regular EPO training to law enforcement officers at their morning roll call meetings. MAWS' new advocacy model allows them to build partnerships and pursue a broader range of solutions.

Key Lesson

Successful advocacy sometimes requires a light touch

While adversarial advocacy approaches often have their place, ongoing policy work requires relationship building, collaboration and compromise — which are often compromised by adversarial tactics. Advocates should consider whether their "target" is truly "the enemy" or could perhaps be a partner for change.

Strategic Steps

Mark Pertschuk, formerly with Americans for Nonsmokers Rights

Lesson:

A "stepwise" strategy of incremental change and compromise can lead to ultimate success—if the steps are chosen wisely.

Background

When the first Surgeon General's Report on Smoking and Health was published in 1964, it established for the first time a link between cigarette smoking and lung cancer in the minds of physicians and the public. Traditional public education efforts led by the three major voluntary organizations (American Heart Association, American Lung Association, American Cancer Society) tried to turn this new awareness into less smoking; however the top-down, education-only approach had limited impact.

Meanwhile, average American citizens across the country were becoming activists determined to protect non-smokers from the harmful effects of secondhand smoke. Between 1975 and 1985 the grassroots nonsmokers' rights movement took hold in California and elsewhere in what was to become a national consumer rights movement to protect nonsmokers' rights to live and work in healthy, smoke-free environments. Activists began to consider policy changes that would restrict secondhand smoke exposure and fundamentally change the everyday environments in which people lived.

The Federal airline smoking ban was one of the greatest achievements of this movement. The ban was first passed in 1987, expanded in 1989, and set the stage for a ban on all flights originating in the U.S. in 2000. This is the story of how activists were able to get landmark Federal legislation passed at a time when the tobacco industry had enormous influence in Washington, D.C., and advocates were just beginning to try policy approaches to health promotion.

The Story

The nonsmokers' rights movement started very small and very local in a handful of states in the late 1970s. In the mid-1980s, advocates formed the organization Americans for Nonsmokers' Rights (ANR) with the modest goal of limiting smoking in public places. In 1986, they sent a newsletter to their grassroots membership with a picture of an airplane on the cover, and received an overwhelming response (with donations) to support the campaign. Before email, or even fax machines, they used letters, first-class postcard action alerts, phone trees, and media advocacy to notify members and the public about pending actions and to ask for feedback.

The response of ANR's membership gave its leadership the mandate to move forward with the campaign to ban smoking on airplanes. Nothing like this had ever been suggested before. Commented Mark Pertschuk, former Executive Director of ANR: "The overwhelming grassroots support was as much of a surprise to the AMA [American Medical Association] and the American Cancer Society as it was to [tobacco giant] Phillip Morris."

Three major scientific reports that came out in 1986 bolstered ANR's case: the National Academy of Sciences report *The Airliner Cabin Environment: Air Quality and Safety*, the Surgeon General's report *The Health Consequences of Involuntary Smoking* and the National Academy of Sciences report *Environmental Tobacco Smoke: Measuring Exposures and Assessing Health Effects*. The NAS airliner cabin report, in particular, "blew the issue out of the water," Perschuk recalled, "because it recommended a complete ban on all smoking on all commercial airline flights." Simultaneously, the media began to cover nonsmokers' rights issues and the ANR campaign. For example, a cover story on "The No Smoking Revolution" in *Business Week* in the late 1980s was read by many people who fly frequently. The article also bolstered the advocates with a sense that they could win the ban.

Although ANR's goal was to ban smoking on all domestic flights through legislation at the Federal level, there was formidable opposition from tobacco companies. These companies had made substantial financial contributions to key members of both political parties in order to influence their votes. The idea to go instead for a ban on flights of two hours or less was presented as a compromise. This represented an incremental step and excluded longer flights where the length of exposure to smoke was more serious. However, the advocates decided to pursue the compromise because it was a strategic step in the right direction that could set the stage for additional wins.

Up to a week before the legislation was passed by the House of Representatives, the tobacco industry was confident that it would not pass. As Pertschuk remembered: "We took them by surprise. [The tobacco companies] thought they could buy off the key Democrats and Republicans." Tobacco lobbyists and their supporters did manage to include a "sunset clause" in the bill that set the new law to expire in three years.

The landmark legislation was passed in 1987 with the sunset clause, and was signed by President Ronald Reagan. Ironically, the sunset clause forced ANR to run a second campaign to extend the legislation, leading to even greater gains for their Smoke-free Skies campaign. ANR used the opportunity to expand the ban to all continental domestic flights. Not only did they achieve this, but they also got the ban to cover all domestic overseas flights of six hours or less, including flights to Hawaii and Guam from the West Coast. This second, more comprehensive law was passed and signed into law by President George H.W. Bush in 1989.

Key Lessons

Pick one objective and stay focused on it

ANR could have participated in several campaigns that were underway at that time, such as efforts to boycott or divest in Phillip Morris, ban tobacco advertising, or raise excise taxes on tobacco products. Many national health organizations did not actively support the airline smoking ban campaign until the first Federal legislation had been passed in 1987 and was a success. For example, it wasn't until 1989 that the AMA got on board with the airline smoking ban. ANR's dedication to the issue laid the foundation for the subsequent smoking ban on all flights between the U.S. and foreign destinations that took effect in 2000.

Be open to compromises that advance your ultimate goals

The feasible but vital step of banning smoking on flights of two hours or less was instrumental in achieving the ultimate goal of a ban on all flights within the subsequent decade.

Community Members as Powerful Advocates

Stephanie Farquhar, Portland State University

Lesson:

Principles of equity can be transformed into practical steps by using Community Based Participatory Research for environmental justice.

Background

The environmental justice movement has demonstrated that pollution and related health effects fall disproportionately on economically and politically disadvantaged communities. Environmental justice advocates demand more than clean air and water; they argue for the participation of all people as equal partners in decision-making regardless of class, race, ethnicity, or national origin. Many public health students ascribe to these ideals, but do not know how to turn their vision of equity and participation into actionable steps.

Community-based Participatory Research (CBPR) has been widely used by environmental justice researchers and activists to do just that. CBPR is a collaborative approach to research that encourages equal partnerships between community members and academic investigators and fosters their joint involvement in addressing environmental health problems. One environmental justice project in Portland, Oregon, demonstrates how CBPR can be used to turn principles into practical steps for social change.

The Story

The Multnomah County Health Department (MCHD) wanted to create programmatic priorities for environmental health based on resident input and participation. MCHD did not have the internal capacity or the public consent to address environmental justice issues. One insider explained that the environmental health services department within MCHD reflected a more traditional approach to environmental disease diagnosis and control, focusing on such things as swimming pool safety, vectors, and food handling. This more traditional mandate, paired with a general mistrust by the public of county agencies, made it difficult for MCHD in isolation to conduct a comprehensive and participatory assessment of environmental health needs.

Using the 13 steps of PACE EH. A coalition to identify and assess environmental health needs was created and guided by the Protocol for Assessing Community Excellence in Environmental Health (PACE EH). This protocol was developed in 1995 by the National Association of County and City Health Officials (NACCHO) and the CDC as a series of 13 steps designed to help local health officials work collaboratively with communities. The protocol helps to identify populations at disproportionate risk of environmental exposure, to assess and

prioritize environmental health concerns, and to create an action plan and evaluation. Within the process used by the PACE Assessment Team were vital preliminary steps: the process of defining and characterizing the community, and the subsequent selection of priority needs and remedial actions.

Forming a coalition. To begin a collaborative process, MCHD worked with several organizations and dozens of residents to form the PACE Coalition during 2002-2005. The PACE Coalition's vision was to create a network of individuals and local organizations who would take an active role in setting an environmental health and justice agenda for Portland communities.

To build relationships with the broader community, MCHD hired two community connectors, or organizers, to reach out to residents and to encourage their participation in the PACE Coalition. In turn, the community connectors informed representatives of government, physicians groups, neighborhood associations, schools, and faith communities about the PACE Coalition. Hiring the community connectors was significant in that it demonstrated MCHD's commitment to a different way of doing business, especially since the hiring happened during state and county budget cuts. PACE Coalition meetings were structured to develop leadership among community members and ease among agency partners who may not be used to working with communities. The PACE Coalition, which included more than 60 members, designated three subcommittees—the Steering Committee, Membership Team, and Assessment Team—to ensure efficiency, ample opportunity for participation, and a fair division of labor.

Criteria used to identify affected communities. The PACE Assessment Team included health department representatives, community residents, community-based organizations, and a faculty member from a local university. The Assessment Team used four criteria to narrow the geographic focus of the project from the entire County to a smaller area. The selection criteria required that the area be (1) home to a large proportion of people of color, (2) low-income, (3) disproportionately affected by multiple environmental and health threats (i.e., an environmental justice community) and (4) once identified, interested in working with the PACE Coalition.

The Assessment Team gathered data and maps documenting the exposure levels of dozens of indicators, including: Cancer Risk per Million Population by Census Tract; Potential Brownfields; Industries Generating Hazardous Waste; Superfund Sites; Pre 1950s Housing; Childhood Lead Poisoning Cases, 1992-2002; Percent of Low Birth Weight Births by Census Tract, 1996-2000; Exposure Concentrations for Diesel Particulate Matter; Exposure Concentrations for Benzene; Illegal Dumpsites; Solid Waste Facilities; Percent of Population at Less than 200% of Poverty; Percent of Non White Population; and Percent of African American, Asian, and Hispanic Populations. The Assessment Team used these maps to determine which areas of the county were most heavily exposed to environmental health hazards, and selected five geographically-defined neighborhoods. In April 2003, the PACE Coalition met to narrow the list. After a community discussion about the maps and the four environmental justice criteria listed above, Coalition participants voted, selecting Inner North/Northeast Portland as the geographic area of greatest immediate concern.

Identifying environmental health priorities in the selected community. Once the community was defined, the community connectors and the Assessment Team conducted extensive outreach to community leaders and residents in the affordable housing communities of Inner North/Northeast Portland, in order to generate the list of environmental health concerns. These residents and leaders helped facilitate additional Assessment Team and Coalition activities. Based on information gathered through personal outreach, community meetings, and assessment activities in summer and fall 2003, the Assessment Team identified a top ten list of environmental health issues that concerned the residents of the neighborhood's affordable housing.

It is important to note that community residents and other members of the PACE Assessment Team discussed aspects of both the physical and the social environment. They did not separate the two but, rather, acknowledged the complex interplay between the social and the physical. For example, many residents talked about feeling unsafe, or the lack of community meeting places, as threats to environmental health and well-being. The top ten issues identified by residents were mold and mildew, pesticides, indoor air quality, outdoor air quality, brownfields, lead, trash and garbage, no meeting places, water quality, and lack of green spaces. The Coalition members, and especially the staff from MCHD, committed themselves to identifying funding that could support sustained efforts in one or more of these priority areas.

Using CBPR findings to secure funding. In 2005, true to their word and using data from the participatory assessment, MCHD and its PACE partners received a $900,000 Housing and Urban Development (HUD) Healthy Homes grant to address the issues of lead, mold, and trash — the very issues that the affected communities identified as the most important. Additionally, some of the members of the PACE Coalition applied for and received 501c3 non-profit status to expand its grassroots advocacy efforts throughout the county outside the purview of local government. The non-profit Organizing People, Activating Leaders (OPAL) recently received grant monies to continue leadership development within the County's environmental justice communities.

Key Lessons

Community wisdom is critical

MCHD thought "outside the box" of traditional approaches to addressing environmental public health threats, by engaging the communities most affected in prioritizing, and crafting solutions to, the problems compromising their health.

Good ideas find a way

Even in the shadow of budget cuts and, ultimately, limitations of local government purview, MCHD and the PACE Coalition found ways to ensure that this community-engaged initiative could thrive and sustain its successes.

[Based on Farquhar S, Patel N, Chidsey M. Preventing Injustices in Environmental Health and Exposures. In L Cohen, V Chavez, and S Chehimi (Eds.), *Prevention is Primary: Strategies for Community Well Being*. San Francisco, CA Jossey-Bass. 2007]

How You Can Do Everything Right and Still Lose...At Least at First

Kirsten Moore, Reproductive Health Technologies Project

Lesson:

You can do everything right to make a policy change happen, and you can still lose…at least for the moment.

Background

Emergency contraception (EC) is an FDA approved, safe, effective method of birth control which when used within 72 hours after unprotected or under-protected sex, dramatically reduces the risk of pregnancy, and by extension, the need for abortion. EC (also known as Plan B) was initially approved for sale only by prescription, rather than for purchase over-the-counter (OTC). However, research shows that EC is more effective the sooner it is used and that making a woman get a prescription and get it filled within that narrow time frame creates an unnecessary barrier to access, particularly for those who do not have a regular health care provider. Thus, the Reproductive Health Technologies Project (RHTP) launched a campaign aimed at FDA approval for making EC available over the counter. They knew this was a high profile political gamble, but that was also the right thing to do for public health. Their strategic and responsive approach provides a useful case study in real-world policy advocacy.

The Story

Less than a year after receiving FDA approval for sale of Plan B emergency contraception in the U.S., the company marketing Plan B began meeting with FDA officials and key stakeholders in the reproductive health and rights community to gauge interest and concerns about a switch from prescription (Rx) to OTC status. RHTP and Center for Reproductive Rights hosted a meeting of women's health advocates, including those who represent women with limited health care access, to explore the issue. In response to concerns raised both by the FDA and women's health advocates, the drug company undertook a "real world" study to show that women, particularly younger women, were not more likely to engage in riskier sexual health behaviors if EC was easily available. The company also explored options for delivering on the widely shared goal of promoting most effective use of EC and improving related reproductive health outcomes.

The company, RHTP, and other groups began making the rounds to meet and brief opinion leaders and members of mainstream medical groups, women's health advocates, policymakers, and other stakeholders (e.g., National Association of Chain Drug Stores). These included small group briefings with relevant decision makers, presentations at annual or membership meetings and academic conferences, and development and dissemination of education materials. In addition to creating buzz on the issue, these meetings gave them a chance to wear down skepticism and identify what roles different constituencies were willing to play in the process.

In February 2001, under the sponsorship of the Center for Reproductive Rights, more than 60 organizations and individuals — including the American College of Obstetricians and Gynecologists, American Academy of Pediatrics, and American Public Health Association — submitted a "citizen's petition" to the FDA, asking it to make Plan B available OTC. The petition helped demonstrate widespread public health support for the switch and kicked off the process of educating the press about the rationale and process for going forward.

Over the next two years, RHTP and allied organizations continued their outreach and education efforts. RHTP conducted public opinion research on how best to communicate what EC is, why it should be OTC, and how their underlying message would need to be tweaked for different audiences (e.g., parents) or developments in the political and policy debate. In April 2003, Women's Capital Corporation (subsequently acquired by Barr Laboratories) filed its application for a switch to OTC status. In preparation for the December 2003 FDA Advisory Committee meeting, RHTP served as an "honest broker" of information between FDA staff and advisors, company representatives, community stakeholders, policymakers and the press to be sure all players knew — to the extent possible — what they could and should expect during the day's debate, and that the 35+ groups that testified in favor of the switch made a consistent and mutually reinforcing pitch. Their expectation was "this should be an evidence-based decision and the evidence is clearly supportive of a switch."

When it began to appear that FDA might *not* make an evidence-based decision, RHTP made sure news of political interference got to the press and stepped up their own pressure on the White House and FDA with an intense coalition-wide letter writing campaign. Their Republican allies, including several "Rangers" (big donors to the Bush campaign), communicated their frustration over the delay directly to the White House. They also began cultivating unlikely activists and messengers — namely highly credentialed scientists, many of whom had no stake in women's health but cared deeply about evidence-based policymaking — through their partnership with the Union of Concerned Scientists and the Integrity of Science Working Group. They also cultivated extensive press and editorial (including cartoon) coverage of the issue.

The initial loss

The FDA's decision to "not approve" the switch was leaked to RHTP a few hours ahead of time, giving them a chance to alert key reporters about the latest turn in events (and thereby drive the message), as well as coalition partners (and thereby fuel the outrage). Their message that teen access was a red herring, and FDA let "politics trump science," dominated coverage, chatter, and spin.

A few weeks after the FDA decision, RHTP received internal FDA memos confirming that three layers of professional staff had recommended approval before the Center Director rejected the application. Again, they carefully placed coverage of these memos in the national press, and editorial pages soon weighed in with their suspicion or scorn. They also helped disseminate a CD-ROM of Dr. W. David Hager — a conservative Christian who promotes abstinence but served on the FDA Advisory Committee — taking credit for helping to stop OTC availability of Plan B.

They brought Dr. Michael Greene, a member of the Committee and former Chair as well as editor for the *New England Journal of Medicine*, to DC to brief key Congressional members about the unprecedented and unwarranted nature of the FDA's decision. This resulted in a request for a Government Accountability Office report on the decision. (The report was subsequently released in November 2005 and confirmed the highly atypical nature of this action.)

A compromise is proposed

In July 2004, the maker of Plan B modified its application, seeking to make the drug available without a prescription to women aged 15 and older, and by prescription-only to those younger than 15 years. While this was a controversial move for many women's health advocates, it was perceived as a compromise and a favorable decision was expected in January 2005. When FDA failed to announce a decision by its internal deadline, the Center for Reproductive Rights filed a legal challenge. The case yielded further paper trails and depositions confirming the degree to which FDA's actions on Plan B went against precedent.

When Dr. Lester Crawford was announced as nominee for FDA Commissioner, RHTP asked key Senators to hold him accountable for heading an agency that had let politics trump science. Despite heavy pushback from coalition partners (and Senators), some very pointed questions on Plan B were asked of Dr. Crawford in his nomination hearing and ultimately Senators Clinton and Murray announced their intention to place a hold on his nomination. Again, throughout this process RHTP cultivated press coverage about a range of concerns raised over Dr. Crawford's credentials and track record as interim FDA Commissioner.

The second loss

The "hold" on Dr Crawford was lifted when the Secretary of Health and Human Services promised that the FDA would "take action" on the application by September 1, 2005. Crawford was confirmed. Two weeks later, he an-

nounced his action would be to suspend review of the application while he submitted the question of whether the agency had regulatory authority to approve a "dual status" (i.e., the same drug being Rx and OTC) to "rule-making," better known as a bureaucratic black hole.

Reframing the issue: The integrity of science campaign

FDA Assistant Commissioner for Women's Health, Susan F. Wood contacted RHTP on the day of the "action" to announce her intention to resign in protest. RHTP worked with Dr. Wood over the next few days to set in motion a process whereby her decision would garner maximum press coverage — yielding stories in all of the major national and regional papers as well as several broadcast programs including *Nightline, ABC World News Tonight*, and *60 Minutes.* RHTP subsequently sponsored her six-month tour of the U.S. to share her outrage and concern about FDA's compromised integrity and ability to deliver on its mission of drug safety.

RHTP and reproductive health advocates successfully reframed the issue from one of reproductive health to one of the threat to evidence-based decision-making that the FDA's action represented. They emphasized the extent to which political interference had compromised the scientific integrity and credibility of the FDA. RHTP was able to garner the support and concern of unlikely activists, namely members of the scientific community that were primarily concerned with the threat to science as the basis of FDA policy.

The win

Suddenly, in September 2005, Crawford resigned citing personal reasons, and President Bush nominated Dr. Andrew von Eschenbach, then-Director of the National Cancer Institute, as acting Commissioner. In October 2005, the General Accounting Office (GAO) released a draft report of their investigation into the FDA's denial of Barr's original application, concluding that the process leading up to the denial was highly unusual, with an atypical level of involvement by high-ranking FDA officials. Congressional pressure began to mount for an explanation of the process and the decision.

When acting Commissioner von Eschenbach was nominated to be Commissioner in July 2006, Congressional representatives pressed for an answer on Plan B before confirmation. One day before his confirmation hearings began, he met with representatives from Barr to resolve the "remaining policy issues" related to making Plan B OTC for women "18 years and older," and then during his confirmation hearing he announced his support for the policy. He was confirmed, and in August 2006, Barr resubmitted its application to sell Plan B OTC. In August 2006, the FDA announced its approval of Barr's application for nonprescription sales of Plan B to women ages 18 and older, and President Bush announced his support for von Eschenbach's decision. RHTP and reproductive health advocates successfully reframed the issue, garnered widespread support for an evidence-based decision on sales of Plan B OTC, and, although a compromise, did ultimately win OTC access through licensed pharmacies for women aged 18-years and older.

Key Lessons

Reproductive Health Technologies Project (RHTP) and reproductive health advocates credit their ultimate success to their efforts to:

Building a strong and diverse coalition
of supporters for the OTC petition and eventually for an evidence-based decision, reaching out to as many parties as they could think of and keeping these stakeholders up to date on the latest events, and soliciting input and feedback throughout the process;

Cultivating excellent working relationships with both business and governmental partners
The commercial sponsor of Plan B and FDA staff and advisors were the ones with the most "leverage," or decision-making power, in this process; RHTP's strong relationships with these internal advocates meant they could weigh in at critical moments and convey information to other stakeholders when appropriate;

Keeping coalition partners "on message"
with the case for an OTC switch, and eventually with their outrage over the politicization of the FDA review process; and

Bringing Congressional members along to exercise their oversight authority
of the FDA and, whenever possible, holding the executive branch accountable for its actions.

Do you want butter with that?
Exposing Health Risks

Liana Winett, Portland State University

Lesson:

Mass media can be used for a narrow target — in this case, a handful of movie theatre owners — and still have impact across the country.

Background

The nonprofit Center for Science in the Public Interest (CSPI) is an oft-described "watchdog" group that focuses on the science, safety, and policy governing food, alcohol, and nutrition. Their reports often generate impressive media coverage that help put pressure on key decision makers with influence over nutrition policies. In 1994, CSPI published a report that cast a critical spotlight on what was arguably an American institution: movie theater popcorn. The immediate success and impressive longevity of that report have helped change industry policy over the 1½ decades that have followed.

The Story

In the spring of 1994, CSPI announced that movie theater popcorn is bad for us — and not just *a little* bad for us. According to the report, *Popcorn: Oil in a Day's Work*, the top-selling movie theater snack — in striking contrast to its air-popped cousin — was loaded with "more than a day's worth of artery-clogging fat." And, as the report noted, "that's without the 'butter.'" With the added butter flavoring, the report continued, a large-sized popcorn of the type sold in most major movie theater chains carried "unhealthy fat…equal to nine McDonald's Quarter Pounders."

The source of this problem was the pervasive use of coconut oil, containing almost 86% saturated fat, favored as the popping medium by a reported 70% of movie theaters at that time. The butter-flavored topping, comprised of partially hydrogenated soy-bean oil, contributed additional unhealthy trans fat and overall fat content to the mix. Both types of fat — saturated and trans — are associated with increases in levels of the "bad" (LDL) cholesterol, a risk factor for cardiovascular disease.

These data revealed something striking: the popcorn served in movie theaters across the nation, which many health-conscious consumers believed to be a preferable alternative to other snacks sold at the concession counter, was remarkably unhealthy.

The goal and target

The goal of CSPI's report was to change industry standards by persuading the nation's major movie theater chains to turn to healthier popcorn alternatives. In the interim, the report also suggested a handful of actions that individual consumers could take to protect their own health.

Ultimately, however, for the situation to improve on a large scale it was movie theater chains nationwide that would need to switch to healthier practices. As such, it was the major movie theater chains and theater owners that were primary targets of this media advocacy effort

Getting media attention

Then-CSPI Communications Director Art Silverman and his team, charged with determining the strategy of this report's release, did for the popcorn study what CSPI had determined to be critical to the success of any of their analyses: they took the scientific details of this story and presented them in a way that reporters and the public would immediately understand and remember.

For example, they converted unappealing and unintelligible "fat-grams" into easily understandable media bites: "the equivalent of nine Quarter Pounders" and "a day's worth of artery-clogging fat." To create a strong visual representation of their argument, CSPI laid out at the press conference a full table of bacon and eggs, a Big Mac and large fries, and a steak dinner — the combined equivalent of the full-day's fat contained in one large tub of movie popcorn. These images created a clear impression of the nature and extent of movie theater popcorn's unhealthy characteristics, and did so in a way that could readily be carried in a news report.

Ultimately and most fundamentally, the topic had built-in emotional appeal. Diet-conscious individuals had trusted popcorn to be a good choice. Parents had thought movie popcorn was a healthy treat for their children. As one source told the *Washington Post*, the report caused "such a completely unexpected source of outrage" (May 12, 1994). And, as Silverman himself has observed, when editors and reporters have a personal stake in an issue, "that doesn't hurt" the success of the story.

Media response

The 1994 popcorn study virtually catapulted onto the national news media stage. The Lexis/Nexis online news database shows that, in addition to the coverage of this story carried on all three television networks and CNN, 61 print news and opinion articles were published in the nation's major newspapers during the interval between April 26 and June 30 1994. More than twice as many stories or columns were published between July 1994 and December 2006, the vast majority of which are not fundamentally about the 1994 popcorn study, *per se*, but instead continued to invoke the original analysis by referring to CSPI in its subsequent work as the-people-who-ruined-movie-popcorn (as well as having "ruined" Chinese, Italian, and Mexican restaurant foods). This story's "staying power," more than a decade following the 1994 press conference, speaks to

the ability of some media advocacy efforts to strike deep cultural chords. As Silverman has noted, "this story had legs."

Representative of CSPI's reports featuring very visual and "quotable" quotes — for example, "heart attack on a plate" for fettuccini alfredo, or the "sniff-and-poke test" for the then-general practice of federal meat safety monitoring — the popcorn study gave rise to a number of memorable media bites that were carried by the nation's news media. For example:

- An average medium buttered movie theater popcorn contains "more fat than a bacon-and-egg breakfast, a Big Mac with fries and a steak dinner with all the trimmings…combined" (e.g., *USA Today* 4/26/94, p.1A; *The Oregonian* 4/26/94 p.A01; *Chicago Sun Times* 5/29/94, p.29).
- ''Theater popcorn ought to be the Snow White of snacks, but instead it's the Godzilla" (e.g., *Pittsburg Post Gazette*, 4/26/94, p. A4; *USA Today* 4/26/94 p.1A; *Washington Post* 4/26/94, p.E1).
- "Theater popcorn is so full of artery-clogging saturated fat that you might as well take a bag of quarter-pound hamburgers to your next movie" (e.g., *New Orleans Times Picayune*, 4/26/94, p.A5)

Repetition of such catchy media bites was one measure of success noted by CSPI. "It was a little victory each time [one] was repeated," said Silverman.

Policy response

The media coverage had its hoped-for effect. A story published in the *Atlanta Journal Constitution* in May 1994, said that AMC Entertainment would make the switch from coconut to less-saturated canola oil in its popcorn, while United Artists would be offering fat-free air-popped corn — both, reportedly, direct results of the CSPI study. In a later story, *Time Magazine* (February 2000) attributed the quick switch among movie houses to "lighter oils" to the highly publicized analysis.

Indeed, in the interval following the story's release all but one of the major chains had announced that they would offer at least somewhat healthier alternatives to conventional theater popcorn. That one chain, however, continued to hold out. In response, Silverman developed a paid advertisement, targeted to run on the movie pages of major cities, which would highlight the refusal of this particular chain to make changes to benefit the health of its patrons. Prior to its publication, CSPI approached the unyielding chain with the advertisement. In the end, this advertisement never needed to run. The chain conceded, announcing it too would make available healthier popcorn in its theaters.

One year later, in June 1995, a follow-up CSPI report asserted that a shift toward healthier popping in the nation's chain theaters was underway. Five of eight leading theater chains were reportedly providing somewhat to significantly healthier alternatives to their prior popcorn offerings. However, by the late 1990's, at least one major chain (AMC Entertainment) announced it would be reintroducing its former coconut-oil popping practice. A spokesman for the theater said this change had been made for "one reason: flavor." (*San Diego Union-Tribune*, June 27, 2001)

Key Lessons

According to former CSPI Communications Director Silverman, the key lessons are:

"Think like journalists"
To the extent that advocates can feed digestible bits of news in formats easily transferable to the specific medium — with minimal work for journalists — it will "increase the chance that the material will be used, surviving relatively in-tact through the journalistic process." Silverman's press releases "read like stories. They were written like a reporter, not a publicist."

Find resonance
"This is paramount." Think of the visual component; develop quotable quotes; identify why this story will matter both to journalists and audiences.

Simplify
"CSPI is blessed by several really good spokespeople. They talk like real people, not scientists." He recommends that advocates develop compelling sound bites that convert the complex into the easily understandable: "Look for accurate presentation in the proper light."

Be ready for "dogged hard work" over the long haul
As Silverman points out, "It was 10 years ago that CSPI launched its campaign against trans fats, and the policy to ban trans fats in New York City just passed in December 2006."

[Based on an interview with Art Silverman on December 15, 2006, as well as news coverage in the following: *Atlanta Journal Constitution, Chicago Sun Times, Cleveland Plain Dealer, New Orleans Times Picayune, Oregonian, Pittsburg Post Gazette, San Diego Union-Tribune, Time Magazine, USA Today, and Washington Post. The* original and subsequent CSPI analyses were published in the *Nutrition Action Newsletter.*]

Changing Targets, Changing Tactics
Dump Diesel Coalition's San Francisco Bus Campaign

Sonja Herbert, Berkeley Media Studies Group

Lesson:

Changing targets requires changing tactics, even within the course of a single campaign.

Background

In 2001, the Dump Diesel Coalition, which included Our Children's Earth, National Resources Defense Council, American Lung Association, Bayview Hunters Point Community Advocates and Sierra Club, came together with an ambitious goal: to phase out diesel buses in San Francisco, California. Diesel fumes have been linked to lung disease, especially asthma in children, as well as cancer, pneumonia, and heart disease. MUNI, the agency in charge of the San Francisco bus fleet, had ignored repeated direct requests from advocates to start replacing diesel buses with cleaner alternatives. In 2001, the Dump Diesel Coalition launched a public campaign to increase pressure on MUNI. Over the course of the three-year campaign, the coalition's goal remained constant — but, its advocacy strategies changed course three times to target different decision makers. With each new target came a refined media strategy with distinct media tactics.

The Story

Target 1: The Board of Supervisors

In 2001, the coalition saw a political opportunity to advance its goals. MUNI needed budget permission from the San Francisco Board of Supervisors to buy new diesel buses. The coalition met with members of the Board of Supervisors and convinced them to take the health and environmental impact of diesel fumes seriously. The Board of Supervisors approved MUNI's purchase of new diesel buses, but with the caveat that MUNI must study what it would take to purchase alternative-fuel vehicles in the future. MUNI complied, but its report discredited all alternative-fuel options. MUNI argued that San Francisco's steep hills would prevent the popular option of natural gas from being feasible, despite its being used in other cities.

The coalition decided to improve the power balance by correcting the information imbalance. In an earlier debate, MUNI downplayed the environmental and health damage done by diesel exhaust by arguing that most of the bus fleet in operation was the cleaner burning diesel buses purchased since 1997. MUNI claimed that the oldest, dirtiest diesel buses were only used in emergencies.

The Dirty Diesel Coalition decided to do its own study. For one week in March 2003, advocates tracked buses leaving two main MUNI lots for their morning runs. By tracking every bus for the same time period and observing multiple locations on multiple days, the coalition created a study that was credible, defensible, and fair. The results showed that 1 out of every 3 buses being used was beyond its "useful life" of 14 years. The study also found that, instead of being used only as an emergency fleet, as MUNI had publicly claimed, the oldest and dirtiest diesel buses were, in fact, in regular, daily use. The coalition had collected the data it needed to make its case.

Since efforts to work directly with MUNI and the Board of Supervisors had not led to significant changes, the coalition developed a media strategy to create pressure on both agencies. Its first media tactic was to create news by holding a press conference outside MUNI headquarters. The location provided a good visual and the coalition also gave reporters a range of authentic voices to interview. The coalition gave the *San Francisco Chronicle* an exclusive early release of the report, which resulted in a news story that captured the coalition's perspective.

Unfortunately, the coalition still did not have the political power it needed. Despite growing support from the San Francisco Board of Supervisors, the Dump Diesel Coalition was discouraged. After two years, MUNI had not taken substantial actions to improve its fleet. Ultimately, MUNI is an independent agency and the Board of Supervisors has limited oversight. The coalition decided it was time to change its strategy and target MUNI decision makers directly.

Target 2: MUNI management

In the summer of 2003, the Dump Diesel Coalition purchased ad space in San Francisco bus shelters with the goal of increasing public pressure on MUNI. The hard-hitting ad took the form of a "Wanted" poster, showing the pollutants spewing from MUNI buses. The coalition chose to place the ads in three strategic locations that would be seen by a large number of MUNI riders, political decision makers, and MUNI officials. The overall strategy was to pressure MUNI directly by asking riders to call the Executive Director of MUNI. Indeed, the ad featured the number for his private office phone line. The coalition supported this community-organizing tactic with the "toxic pass," which was cleverly designed to mimic a MUNI monthly "Fast Pass" and was handed out at bus shelters. The "toxic pass" described the dangerous health effects of MUNI's diesel bus fleet in language relevant to people who ride the buses regularly.

The tone of this media strategy was intentionally confrontational. The coalition wanted quick, tangible action from MUNI officials to move the issue forward. MUNI responded by quietly pressuring Viacom, the company in charge of bus shelter advertising, to reject the ads. A clause in MUNI's own contract with Viacom gave them this option. The advocates had done their homework and knew that Viacom had accepted ads from political and nonprofit causes in the past. The coalition had a lawyer write a letter to MUNI and Viacom hinting at legal action for its possibly discriminatory actions.

Then, the coalition gave the story to two political columnists at the *San Francisco Chronicle*, who ran the item as the top story along with a reproduction of the "Wanted Dirty Diesel Bus" ad. Within 48 hours of the news report, the head of MUNI signed off on Viacom accepting the ad. The media strategy of paid advertising had a powerful earned media benefit — a news story about the controversy over the ad. But the controversy over the ad wasn't the only thing discussed in the story. The coalition also got the opportunity to explain why it purchased the ads, and to repeat its policy goal: to eliminate diesel buses.

Target 3: San Francisco voters

Two years after the coalition's initial request for MUNI to phase out diesel buses, MUNI had yet to take significant action to clean up its fleet. So, the coalition once again changed its strategy. This time, the target was the people of San Francisco. The Dump Diesel Coalition placed Proposition I on the March 2004 ballot. The initiative required an official plan for phasing out the dirtiest diesel buses, allowing MUNI to apply for a one-year extension, if necessary.

The new advocacy strategy required a new communications strategy. The first step was for the coalition to change its name from "Dump Diesel Coalition" to "Coalition for Clean and Reliable MUNI," a more positive title that would appeal to voters. Also, the coalition wanted to emphasize that newer buses would help improve the reliability of MUNI — a chief concern in transit-focused San Francisco. In 2004, the coalition held a kickoff press conference with three supervisors and a host of advocates gathered outside the largest MUNI depot in the city. Creating a powerful visual, the supervisors poured a gallon of coal soot into a bucket — representing the toxic pollution one diesel bus expels every single day. This caught the attention of reporters, and the crushed coal/diesel soot image was shown repeatedly on TV newscasts on the midday, afternoon, and evening news. In March of 2004, Prop I won by a landslide with 67% of the vote.

Key Lessons

Prepare to make your case

MUNI's statements minimized the health and environmental effects of diesel buses and discredited alternative options. The coalition was able to fire back after it collected its own data that revealed a much more serious problem than MUNI's research had suggested.

Changing targets requires changing tactics

Over the course of the three-year campaign, the overall goal of getting MUNI to phase out diesel buses remained constant. But as the coalition targeted different decision makers, it developed new advocacy strategies with distinct media tactics.

Provide reporters what they need to tell the story

With each new media strategy, the coalition used a variety of newsworthy elements to provide reporters with what they needed to tell a good story. Throughout the

campaign, the coalition created news with drama, such as juxtaposing MUNI's claims with independently collected data. The coalition understood the value of using interesting visuals. Authentic voices — of people affected by the diesel exhaust, policymakers, and researchers — made the story come alive and showed the diversity of support for diesel-bus retirement.

[Adapted from The California Endowment's Communicating for Change Curriculum for the Health ExChange Academy.]

When Voluntary Business Policies Are Your Only Option
The Campaign for Safe Cosmetics

Sonja Herbert, Berkeley Media Studies Group

Lesson:

Advocates can combine hard-hitting media tactics with community-organizing efforts to achieve their goals.

Background

Chemicals the government classifies as "known human carcinogens" are found in 1 in 100 health and beauty products. "Possible human carcinogens" can be found even more often, in 1 of every 3 products. In 2002, a coalition of health and environmental groups created the Campaign for Safe Cosmetics to address this problem. Members of the campaign came together out of a concern about the widespread use of health-compromising chemicals in our society. Its goal was to phase out the use of chemicals that are known or suspected to cause cancer, genetic mutations, or reproductive harm.

The Story

The advocates' first strategic choice was to target cosmetics products. Cosmetics offered a fitting inroad to address the larger problem since many of these chemicals are most dangerous for women of reproductive age, who also use many health and beauty products. The coalition realized early that changing consumer behavior would not be enough to achieve its goal; the chemicals were too widely used in the industry for consumers to be able to avoid them. The coalition saw two options for improving the products at the source: strengthening FDA regulation of cosmetics or getting companies to voluntarily change their formulas. The first might lead to broader change in the regulation of toxic chemicals, but it seemed politically unlikely. The coalition chose instead to target the $35-billion dollar cosmetics industry.

Since the problem was widespread, the coalition didn't single out one company. Instead, it asked all companies selling cosmetics in the US to sign the Compact for Safe Cosmetics. The compact built on the action of the European Union, which in 2003 banned the use of chemicals in personal-care products that are known or strongly suspected of causing cancer, mutations, or birth defects. Many companies selling such products in the US would have to reformulate them for the European market anyway, so the coalition hoped to build on this momentum. By signing the compact, companies agreed to remove from their products chemicals banned by the EU within three years. Going beyond the EU requirements, companies were also asked to do an inventory of all product ingredients and replace hazardous ingredients with safe alternatives.

The coalition used many advocacy strategies to reach industry executives, including letters, shareholder resolutions, and demonstrations at company headquarters. It also organized advocates to pressure salon owners to stop using toxic products, which would help create a safer working environment for employees. These advocacy tactics successfully convinced some companies to sign or support the compact. But the industry leaders — the companies with the largest market share — still refused to sign.

In September 2004, the coalition decided to shine a spotlight on the issue by engaging the media. As a small campaign, it had to be very strategic about what type of media it pursued. The coalition purchased paid advertising space in the New York edition of *USA Today* to appear on the day of a major cosmetics-industry conference being held in New York City. All the industry executives attending the conference would see the ad, as *USA Today* would be delivered right to their hotel-room doors. The executives might assume that every *USA Today* reader also saw this unflattering portrait of the industry. The confrontational ad asked leading companies by name to follow the European standards for their US-sold products. The ad was discussed in detail at conference sessions and generated news coverage, such as a long article in the trade journal *Women's Wear Daily*. In describing the Campaign for Safe Cosmetics, the Vice President of Global Communications for Estee Lauder, Janet Bartucci, told the *WWD* reporter that "these are not fly-by-night activists. These are people who are really great at coalition-building and extremely consistent with their messages." The reporter noted that Bartucci spends "115% of her time monitoring agitators and devising response strategies." As Bartucci put it, "The industry can't sit back and roll over anymore…this is a whole new ballgame."

The cosmetics industry was not silent. The day the ad ran, Revlon contacted the coalition to say that its products comply with the EU standards; advocates had been trying for more than a year to get a response from Revlon. The coalition reused this same ad later that year to reach Hollywood actors, fashion models, and L'Oreal executives attending the Cannes film festival. In two years, over 400 cosmetics companies signed on or endorsed the concept. While industry leaders such as Estee Lauder, Proctor and Gamble, Unilever, Revlon, and L'Oreal refused to sign the compact, they edged closer to its goals by reformulating globally to meet the EU standards. In September 2006, OPI, the world's leading nail-polish manufacturer, agreed to stop using the hazardous chemical dibutyl phthalate, which has been shown to cause birth defects in baby boys, in its products. OPI had been targeted by the coalition earlier that summer with a hard-hitting ad campaign and protests in 75 cities. Throughout the four-year effort, the Campaign for Safe Cosmetics strategically designed its media work so that it reached particular targets and supported the overall advocacy goals.

Key Lessons

Define the problem carefully

The organizations that formed the Campaign for Safe Cosmetics strategically chose to focus on one part of a larger problem. The cosmetics issue allowed advocates to address one way in which people are exposed to hazardous chemicals in our society, while still highlighting a flawed regulatory system that affects all chemicals.

Choose your target and solution strategically

The coalition focused on changing the voluntary behavior of the cosmetics industry since the political climate made it unlikely that the FDA would take strong regulatory actions.

Develop a media strategy that supports your overall strategy

The coalition used many advocacy strategies to reach industry leaders. When those stalled, they engaged the media creatively with paid ads designed to reach specific targets through a carefully chosen outlet. The message in the ad matched that of the larger campaign: cosmetics companies should sign the compact for safe cosmetics.

[Adapted from The California Endowment's Communicating for Change Curriculum for the Health ExChange Academy.]

B

A Note on Learning and Service Outside the Public Health Classroom

by Stephanie Farquhar and Nancy Goff,
Portland State University

Overview of service learning

In the last several decades, universities and colleges have been asked to reexamine their roles in communities. Historically, the university was seen as a training center for community leaders, providing them with the knowledge and skills necessary to tackle social problems. Yet, the university has become increasingly disconnected from the community, and the relevance of students' preparation for an active civic life has been examined (Jacoby, 1996).

Service learning provides one mechanism for increasing the relevance, richness, and usefulness of students' learning. It has been defined in many ways, but generally *service learning* refers to "the various pedagogies that link community service and academic study so that each strengthen the other" (Ehrlich, 1996, p.xi). During service learning, the students participate in community or organizational experiences that are integrated in theory and practice into the content of a concurrent course. The opportunity for students to reflect on their community activities enriches the student's experience as well as the communities they serve.

Service learning is grounded in two key principles that make it distinct from traditional volunteering or internships — *reflection* and *reciprocity* (Jacoby, 1996). These principles are informed by the writings of American philosopher John Dewey, in which Dewey asserted that the function of schooling is to endow students with the skills

and knowledge necessary to be active community participants and democratic citizens (Dewey, 1938; Jacoby, 1996). *Reflection* involves placing the experience in a larger context. Students learn about the structures and policies at the macro level (e.g., social, economic or environmental) that affect their experiences at the micro (community or organizational) level. Instructors and students work together to add meaning to their experiences.

The other key principle guiding service learning is *reciprocity*, whereby students, instructors, and the community learning from one another in a mutually respectful and trustful relationship. This is distinct from the approach in early community service activities which emphasized a unidirectional flow of skills, knowledge, and resources from the volunteer to the community member. Contemporary service learning takes a contrary view. Communities are instead viewed as a wealth of potential skills, knowledge, and resources that is shared with students and instructors. It is acknowledged that reciprocity and two-way learning can occur in both the community-student relationship and in the student-instructor relationship. Material taught by university and college instructors is augmented by the practice-oriented perspective of involved students (Jacoby, 1996). Additionally, the principle of reciprocity suggests that the community defines its own needs, rather than having its needs defined by student and instructor. By defining their own priorities, community members are more likely to be better equipped to identify and deal with future issues (Jacoby, 1996).

Some distinguish civic engagement from service learning by acknowledging that service learning is just one type of civic involvement. Civic engagement is viewed more broadly and can include such activities as individual voluntarism, participation in electoral and legislative processes, serving as a member of a neighborhood association, and community organizing.

Service learning places equal emphasis on the service and the learning. Instructors ask students to reflect on and integrate their experiences with classroom material, and apply what they've learned in other situations (Kolb, 1975). For example, students may work in small groups and identify similarities and differences in how they experience significant events of their service-learning project, thereby highlighting variations in learning and worldviews. Students may also maintain a journal that chronicles their experiences and then compare these experiences to what they are learning in the classroom and textbooks. This practice encourages students to identify congruencies or discrepancies with classroom material, encouraging a critical review of public health theories, principles, and frameworks. In addition to increased awareness of community issues and civic responsibility, students gain skills in problem solving, teamwork, communication skills, reasoning, decision making, compromise and negotiation (Jacoby, 1996, p.21). Students also have the opportunity to gain a deeper understanding of broad principles such as diversity, social justice, and interconnectedness.

Faculty can fulfill their primary responsibilities of research, service and teaching through service learning programs (Zlotkowski, 1998), and faculty involvement and enthusiasm is perhaps the greatest predictor of the success of service learning programs (Bell, 2000). Institutions can provide resources, incentives, and assistance to instructors using service-learning in their classrooms, and institutional characteristics such as an accepting culture, integration into the campus mission and activities, and recruitment of supportive faculty and staff, can increase the sustainability of service learning programs. Below is a list of 11 additional factors that can increase the likelihood of a successful service learning program.

11 tips to successful service learning

1 Educate yourself about the different types of practice and the benefits and challenges of service-learning; know the philosophy and principles that inform service learning

2 Talk to other faculty who have successfully incorporated service learning into their classrooms; learn from their successes and challenges

3 Know the organization and the potential preceptor; approach organizations with which you have an existing relationship and begin to establish relationships with those you do not

4 Plan ahead with the organization; coordination of schedules and ensuring the organization's full understanding of the content and aims of the course is important

5 Adequately orient the students to the structure and benefit of this type of learning; initially students may be frustrated by the extra demand on their time if they do not fully appreciate the benefits of the service learning project

6 Anticipate potential challenges and be prepared to respond to those challenges

7 Mutually agree upon projects or activities by consensus of the organization, the student, and the instructor; you should all have a clear sense of what the student is to do throughout the term

8 Require the students to develop a strategy or plan and personal learning objectives; these documents will serve as a guide and reference throughout the term

9 Be realistic about how much can be accomplished; most service learning projects require a limited number of hours and must fit within a quarter or a semester

10 Encourage students and organizations to report progress and problems early and often, if necessary

11 Offer to 'give back' to the organization for their time and invaluable contribution, including your consultation or evaluation services, for example

Menu of ways to integrate practicum

For a variety of reasons, including lack of resources, time, on-line course format, and geographic remoteness, some faculty and campuses are unable to add a service learning component to their curriculum. There are other ways to integrate practicum or experiential opportunities.

- Community or organizational field trips that expose students to issues that are relevant to course content
- On-campus or off-campus events to raise awareness of a community issue
- Short term career immersion program for students
- Speakers who are from the communities affected by the issues, or represent the organizations discussed in the classroom
- Service activities incorporated into student orientations, conferences, or curricular requirements (e.g., internships)
- Service activities organized by student groups
- Intensive service vacations or study abroad programs
- Participation in faculty or staff research that is conducted in the community or with organizations

Case study: Coalition for a Livable Future

The Coalition for a Livable Future (CLF) has participated in the graduate-level Community Organization for Health course for 3 consecutive years. CLF is a partnership of over 90 organizations working to shape public policy decisions that affect the long-term health and sustainability of the Portland, Oregon, region. In the words of CLF Director, Jill Fuglister, part of what makes CLF's experience with the class so useful is the ability to identify projects that build on each other year after year. "*Working with students from the Community Organizing class has been a great experience for us. Last year, the two students we worked with were involved in our transportation campaign, assisting with outreach and citizen organizing. This year we are building on this work by having the students help create health impact assessments (for) our transportation work. The students have been very professional and skilled, adding tremendous value and capacity to our work.*" Fuglister identified as the primary challenge, "*having the time to provide the students with sufficient support.*"

Fuglister worked with the instructor and graduate research assistant to define two projects that could be shaped to fit course requirements and student interests. The first project was the Columbia River Crossing Health Impact Assessment Project whereby students assisted with the development of an Environmental Impact Statement to evaluate the rebuilding of the Interstate 5 bridges along the Columbia River. The second project was to conduct outreach for the Regional Equity Atlas, a series of fifty maps used to explore equity in the Portland metropolitan region. Students helped organize and facilitate community forums, providing assistance to volunteer facilitators, and preparing a final report to guide the work of the CLF's Equity Action Plan Committee.

CLF service learning students, Stacey Sobell Williams and Nancy Goff, described their experience with CLF: "*Working with CLF has allowed us to put into action some of the principles that we learn in class, and to critically reflect on what it means to 'do' community organizing. While working with CLF has helped to illuminate many of the ideas put forth in the classroom, there has also been occasional dissonance between classroom concepts and real-world practice. This dissonance has been especially helpful, forcing us to re-evaluate our ideas of what community organizing is or should be, and ultimately leading to a fuller understanding of class concepts. We have given time and energy to help CLF with their projects, and in return CLF has given us an opportunity to ground-truth what we learn in class, and in some instances, to help shape their actions. This reciprocity continues back in the classroom where the instructor and students all share, learn from, and reflect on each other's experiences. Ultimately, working with CLF has given us a sense of attachment to course theories and concepts — a feeling that isn't gained from learning about community organizing, but from helping to make it happen*."

Resources and websites

Campus Compact, a national organization with over 1,100 college and university members, is dedicated to service learning, providing funding, knowledge and resources to enable members to implement successful campus programs (http://www.compact.org/).

Learn and Serve America's National Service-Learning Clearinghouse provides information and resources to support service-learning programs, practitioners, and researchers, including national email discussion lists and a library collection (http://www.servicelearning.org/).

Michigan Journal of Community Service Learning (MJCSL) is a national, peer-reviewed journal consisting of articles written by faculty and service-learning educators on research, theory, pedagogy, and issues relevant to the service-learning community (http://www.umich.edu/~mjcsl/).

Bringle, R. G., Games, R., and Malloy, E.A. (1999) *Colleges and Universities as Citizens*. Needham Heights, MA: Allyn and Bacon.

Cress, C.M., Collier, P.J., and Reitenauer, V.L. (2005) *Learning Through Serving: A Student Guidebook for Service Learning Across the Disciplines*. Sterling, VA: Stylus.

Gelmon, Sherril B., Barbara Holland, Amy Driscoll, Amy Spring, and Seanna Kerrigan. *Assessing Service-Learning and Civic Engagement: Principles and Techniques*. Providence, RI: Campus Compact, 2001 (access at http://www.service learning.org/lib_svcs/lib_cat/index.php?library_id=4207)

Stanton, T., Giles, D. and Cruz, N. (1999) *Service-Learning: A Movement's Pioneers Reflect on Its Origins, Practice, and Future.* San Francisco, CA: Jossey-Bass.

References

Bell, R., Furco, A., Ammon, M.S., Muller, P., and Sorgen, V. (2000). *Institutionalizing Service-Learning in Higher Education: Findings from a Study of the Western Region Campus Compact Consortium*. Submitted to the Western Region Campus Compact Consortium, Bellingham, WA.

Dewey, J. (1938, 1997) *Experience and Education*. New York: First Touchstone Edition.

Ehrlich, T. (1996). Foreword. In B. Jacoby (Ed.), *Service Learning in Higher Education* (pp. xi-xvi). San Francisco, CA: Jossey-Bass Publishers.

Jacoby, B. (1996). Service-Learning in Today's Higher Education. In B. Jacoby (Ed.), *Service Learning in Higher Education* (pp. 3-25). San Francisco, CA: Jossey-Bass Publishers.

Kolb. D. A. and Fry, R. (1975) Toward an Applied Theory of Experiential Learning. In C. Cooper (Ed.) *Theories of Group Process*, London: John Wiley.

Zlotkowski, E. (1998) *Successful Service Learning Programs*. Bolton, MA: Anker Publishing Company, Inc.

C

Bibliography

works cited

Adler N, Boyce T, Chesney M, Folkman S and Syme L. Socioeconomic Inequalities in Health. *Journal of the American Medical Association*, 269(24): 3140-3145. 1993.

Alinsky S. *Rules for Radicals*. Vintage Books: New York. 1971.

Appell D. Ashcroft letter to Clinton. The New Uncertainty Principle: *Scientific American*, 2001; 284:18-19.

Bagdikian BH. *The New Media Monopoly* (Foreword, Preface, and Chapters 1, 2 and 6). Beacon Press: Boston, MA. 2004.

Bagnell SJ. Necessity leads to innovative evaluation approach and practice. *The Evaluation Exchange*, 13(1):10-11. 2007. [Available at www.hfrp.org]

Bardach E. *A Practical Guide for Policy Analysis: The Eightfold Path to More Effective Problem Solving* (2nd ed.). CQ Press: Washington, D.C. 2005.

Barry B. *Why Social Justice Matters*. Polity Press: Cambridge, UK. 2005.

Bayer R, Gostin LO, Jennings B, and Steinbock B (Eds). *Public Health Ethics: Theory, Policy, and Practice*. Oxford University Press: New York. 2006

Beauchamp D. Public Health as Social Justice. *Inquiry*, XIII (March):3-14. 1976.

Bell J. Learning to Lobby: Steps to Successful Legislative Advocacy. *Race, Poverty and the Environment*, Vol. 10 No. 2, pp. 41-45, Fall 2003.

Belden, Russonello, and Stewart. "Using survey research to evaluate communications campaigns." Media Evaluation Project. Communications Consortium Media Center: Washington, DC. 2004. [Available at www.mediaevaluationproject.org]

Bergman AB (Ed.). *Political Approaches to Injury Control at the State Level*. University of Washington Press: Seattle. 1992.

Birkland TA. *An Introduction to the Policy Process. Theories, Concepts and Models of Public Policy Making* (2nd ed.). M.E. Sharpe: Armonk, NY. 2005.

Blair E. Evaluating an issue's position on the policy agenda: The bellwether methodology. *The Evaluation Exchange*, 13(1):29. 2007. [Available at www.hfrp.org]

Bobo K, Kendall J, and Max S. *Organizing for Social Change: A Manual for Activists in the 1990s*. Seven Locks Press: Santa Ana, CA. 2001.

Butterfoss F. *Coalitions and Partnerships in Community Health*, Jossey-Bass: San Francisco. 2007.

Butterfross F. Essential coalition processes (chapter 7). *Coalitions in Community Health*, Jossey-Bass: San Francisco, 2007.

California Senate Rules Committee. How a Bill Becomes Law. California Office of Senate Reprographics. March, 2001.

Chapman S. Advocacy in Public Health: Roles and Challenges. *International Journal of Epidemiology*, 30: 1226-32. 2001.

Chapman S, and Lupton, D. *The Fight for Public Health: Principles and Practice of Media Advocacy*. BMJ Publishing Group: London. 1994.

Chávez V, Duran B, Baker Q E, Avila MM, and Wallerstein N. The dance of race and privilege in community-based participatory research. In M. Minkler and N. Wallerstein (Eds.), *Community-based Participatory Research for Health* (pp. 81–97). Jossey-Bass: San Francisco. 2003.

Cohen D. "What is Advocacy?" *Volume 1: Reflections on Advocacy*. Advocacy Institute, 2001.

Cohen L, Chávez V, and Chehimi S. *Prevention Is Primary: Strategies for Community Wellbeing*. Jossey-Bass: San Francisco. 2007.

Cohen L, Chavez V, and Chehimi S (eds.). Beyond brochures: The imperative for primary prevention (chapter 1). *Prevention is Primary: Strategies for Community Wellbeing*, San Francisco: Jossey-Bass, 2007.

Cohen L, Chavez V, and Chehimi S (eds.). Working collaboratively to advance prevention (chapter 7). *Prevention is Primary: Strategies for Community Wellbeing*, San Francisco: Jossey-Bass, 2007.

Cohen L, Swift S. The spectrum of prevention: Developing a comprehensive approach to injury prevention. Injury Prevention, 1999; 5:203-207.

Consumers Union. "Legislative Advocacy Glossary." February, 2002.

Dahlberg LL, Krug EG. Violence-a global public health problem. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. *World Report on Violence and Health. Geneva, Switzerland: World Health Organization; 2002*:1-56. Available at http://www.cdc.gov/ncipc/dvp/Social-Ecological-Model_DVP.htm

Dawson A, and Verweij M (Eds). *Ethics, Prevention, and Public Health*. Oxford University Press: New York. 2007.

Doll, R. Health and the environment in the 1990s. *American Journal of Public Health*, 82(7): 933-941. 1992.

Dorfman, L. Using Media Advocacy to Influence Policy. In RJ Bensley and J Brookins-Fisher (Eds.), *Community Health Education Methods: A Practitioner's Guide* (2nd edition; Chapter 15). Jones and Bartlett Publishers: Sudbury, MA. 2003.

Dorfman L, Wallack L, and Woodruff K. More than a message: Framing public health advocacy to change corporate practices. *Health Education and Behavior*, 32(4):320-336. 2005.

Douglas Gould and Company. "Writing a Media Analysis." Prepared for the Communications Consortium Media Center. 2004. [Available at www.mediaevaluationproject.org]

Durland M, and Fredericks K (Eds.). *New Directions for Evaluation: Social Network Analysis in Program Evaluation* (Vol. 107). Jossey-Bass: New York, NY. 2005.

Ehrlich T. *Civic Engagement, Civic Responsibility, and Higher Education*. Oryx Press: Westport, CT. 2000.

Evans RG, Barer ML, and Marmor TR. *Why Are Some People Healthy and Others Not?* Aldine De Gruyter: New York. 1994.

Fetterman D and Wandersman A. *Empowerment Evaluation Principles in Practice*. Guilford Press: New York. 2004.

Ferris S, and Sandoval R. *The Fight in the Fields: César Chávez and the Farmworkers Movement*. Harcourt Orlando, FL. 1997.

Fink M. In the Treatment of Diabetes, Success Often Does Not Pay. *New York Times*. January 11, 2006.

Fisher R, and Romanofsky P. Introduction. In R. Fisher and P. Romanofsky (Eds.), *Community Organization for Social Change* (pp. xi–xviii). Greenwood Press: Westport, CT. 1981.

Freire P. *Pedagogy of the Oppressed*. Seabury Press: New York. 1970.

Gamble VN, Stone D. US Policy on Health Inequities: The Interplay of Politics and Research. *Journal of Health Politics, Policy and Law*, 31:93-126. 2006.

Gamble VN, Stone D. US Policy on Health Inequities: The Interplay of Politics and Research. *Journal of Health Politics, Policy and Law*, 31:93-126. 2006.

Gebbie KM, Rosenstock L, and Hernandez LM. *Who Will Keep The Public Healthy?* National Academies Press: Washington, D.C. 2003.

Gehlert, S, Sohmer D, Sacks T, Mininger C, McClintock M, and Olopade O. Targeting health disparities: A model linking upstream determinants to downstream interventions. *Health Affairs*, 27(2): 339-349. 2008.

Geiger H J. The unsteady march. *Perspectives in Biology and Medicine*, 48:1–9. 2005. Retrieved July 25, 2006, from ww.phrusa.org/racial_disparities/pdf/geiger_unsteady-march.pdf.

Green L. Letter to the Editor. *Health Education Quarterly*, 14(1): 3-5.1987.

Goldwater B. Early Stirrings: The Forgotten American. *Conscience of a Majority.* Prentice-Hall: Englewood Cliffs, N.J.. 1970, pp. 9-23.

Gordon L. Public Health is More Important Than Health Care. *Journal of Public Health Policy*, 15(3):261-264. 1993.

Guralnik J, and Leveille S. Annotation: Race, Ethnicity, and Health Outcomes — Unraveling the Mediating Role of Socioeconomic Status. *American Journal of Public Health*, 87(5): 728-729. 1997.

Guthrie K, Louie J, and Foster CC. *The Challenge of Assessing Policy and Advocacy Activities: Strategies for a Prospective Evaluation Approach*. Blueprint Research and Design and The California Endowment: Los Angeles, CA. 2005. [Available at www.calendow.org.]

Haddon W. A logical framework for categorizing highway safety phenomena and activity *Journal of Trauma*: 1972;12:193-207.

Harvard Family Research Project. Advocacy and policy change. *The Evaluation Exchange*, 8(1):1-32. Cambridge, MA. 2007. [Available at www.hfrp.org.]

Hofrichter R (Ed). *Health and Social Justice: Politics, Ideology, and Inequity in the Distribution of Disease*. Jossey-Bass: San Francisco. 2003.

Holton R. Reflections on Public Policy Grant Making. *Reflections*. The California Wellness Foundation: 2002, pp. 2-4, 11-17.

hooks b. *All About Love: New Visions*, Perennial: New York. 2000.

How a Bill Becomes a Law — The Real Version. Other Views. *Sacramento Bee*. October 2, 2001.

Huppert JS, Adams Hillard PJ. Sexually Transmitted Disease Screening in Teens. *Current Women's Health Reports*, 3:451-8. 2003.

Institute of Medicine. *The Future of the Public's Health in the 21st Century* (Chapter 7). National Academies Press: Washington DC. 2003.

Institute of Medicine. *The Future of Public Health*. Institute of Medicine: Washington, DC. 1988.

Israel B, Schulz A, Parker E, and Becker A. Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health*, 19:173-202. 1998.

Jacobs J. The Legislator. *A Rage for Justice*. University of California Press: 1995, pp. 198-216.

Jones C. Levels of Racism: A Theoretic Framework and a Gardener's Tale. *American Journal of Public Health*, 90(8);1212-15. 2000.

Kaplan G, Pamuk E, Lynch J, Cohen R, and Balfour, J. Inequality in income and mortality in the United States: Analysis of mortality and potential pathways. *British Medical Journal*, 312: 999-1003. 1996.

Kawachi I, Kennedy B, Lochner K, and Prothrow-Stith D. Social Capital, Income Inequality, and Mortality. *American Journal of Public Health*, 87(9): 1491-98. 1997.

Kawachi I, Kennedy BP, and Wilkinson RG. *The Society and Population Health Reader: Income Inequality and Health*. The New Press: New York. 1999.

Kessler D. Opening Battles. Chapters 8 and 10. *A Question of Intent*. Public Affairs: New York, 2001, pp. 54-59 and 67-71.

Kent C. STD surveillance: Critical and costly, but do we know if it works? *Sexually Transmitted Diseases*, 24(2);81-2. 2007.

Kingdon J. *Agendas, Alternatives and Public Policies*. Addison Wesley Educational Publishers: New York. 1995.

Kliegman R. Neonatal Technology, Perinatal Survival, Social Consequences, and the Perinatal Paradox. *American Journal of Public Health*, 85(7): 909-913. 1995.

Kretzmann J P, and McKnight J L. *Building Communities From the Inside Out*. Northwestern University, Center for Urban Affairs and Policy Research: Evanston, IL. 1993.

Kluger R. *Simple Justice: The History of Brown v Board of Education and Black America's Struggle for Equality*. Knopf: New York, 1976.

Last J. *Public Health and Human Ecology*. Appleton and Lange: Stamford, CT (2nd ed.). 1998.

Lao-Tzu. *Tao Te Ching*. A new translation by Gia-Fu Feng and Jane English. Random House: New York, 1972.

Lewin NL, Vernick JS, Beilenson PL, Mair JS, Lindamood MM, Teret SP, Webster DW. The Baltimore Youth Ammunition Initiative: A Model Application of Local Public Health Authority in Preventing Gun Violence. *American Journal of Public Health*, 95:762-5. 2005.

Lewin NL, Vernick JS, Beilenson PL, Mair JS, Lindamood MM, Teret SP, et al. The Baltimore Youth Ammunition Initiative: A Model Application of Local Public Health Authority in Preventing Gun Violence. *American Journal of Public Health*, 95(5):762-765. 2005.

Lubchenko, J. Entering the Century of the Environment: A New Social Contract for Science. *Science*, 1997 AAAS presidential address 1998; 297:491-497.

Lytton TD. Using Litigation to Make Public Health Policy: Theoretical and Empirical Challenges in Assessing Product Liability, Tobacco, and Gun Litigation. *Journal of Law, Medicine and Ethics*, Winter:556-564. 2004.

Mann J. Medicine and Public Health, Ethics and Human Rights. *Hastings Center Report* (pp. 6-13). May-June, 1977.

Mann, Jonathan M., Gruskin, Sofia, Grodin, Michael A. *Health and Human Rights: A Reader.* Routledge: New York and London, 1999.

Marmot, MG. Creating healthier societies. *Bulletin of the World Health Organization*, 82(5): 320-321. 2004.

Marmot M, and Wilkinson RG (Eds.). *Social Determinants of Health*. 2nd Edition. Oxford University Press: London. 2006.

Marmor T. *The Politics of Medicare* (2nd ed.). Aldine Transaction: Piscataway, NJ. 2000.

Matthews C. Don't Get Mad; Don't Get Even; Get Ahead. *Hardball: How Politics is Played, Told By One Who Knows the Game*. Simon & Schuster: New York. 1999, pp. 105-115.

McKeown T. Determinants of Health. *Human Nature*, 1(4):60-67. 1978.

McKinlay JB, Marceau LD. To Boldly Go… *American Journal of Public Health*, 90(1):25-33. 2000.

McKnight J L. Regenerating community. In J. L. McKnight, *The Careless Society: Community and its Counterfeits* (pp. 161–172). New York: Basic Books. 1995.

Mebane F and Blendon R. Political Strategy 101: How to Make Health Policy and Influence Political People. *Journal of Child Neurology*, 16:513-19. 2001.

Michaels D, Monforton C. Manufacturing Uncertainty: Contested Science and the Protection of the Public's Health and Environment. *American Journal of Public Health*, 95:S39-S48. 2005

Milio N. *Promoting Health through Public Policy*. F.A. Davis Company: Philadelphia. 1981.

Minkler M and Pies C. "Ethical Issues and Practical Dilemmas in Community Organization and Community Participation." In Minkler M. (Ed.), *Community Organizing and Community Building for Health* (pp. 116-132). Rutgers University Press: Piscataway, NJ. 2005.

Minkler M. *Community Organizing and Community Building for Health*. Rutgers University Press:

Minkler M. Personal Responsibility for Health: A Review of the Arguments and the Evidence at Century's End. *American Journal of Public Health*, 26(1):121-140. 1999.

Minkler M. Understanding coalitions and how they operate as organizations.(chapter 16). *Community Organizing and Community Building for Health*. Piscataway, NJ: Rutgers University Press, 2005.

Nyswander DB. Education for Health: Some Principles and their Application. *Health Education Monographs*, 14: 65-70. 1956.

Patton MQ. *Utilization-Focused Evaluation: The New Century Text*. Sage Publications Thousand Oaks, CA. 1997.

Patton MQ. Evaluation for the way we work. *The Nonprofit Quarterly*, 13(1): 28-33. 2006.

Peck MS. *The Different Drum: Community Making and Peace*. Simon and Schuster: New York. 1987.

Perez V. The Secret of César Chávez Leadership. *World Hispanic Magazine*, 2004.

Pintado-Vertner R. *The West Coast Story: The Emergence of Youth Organizing in California.* Funders' Collaborative on Youth Organizing: New York. 2004.

Polednak AP. *Segregation, Poverty, and Mortality in Urban African Americans*. Oxford University Press: New York. 1997.

Powell LF. Attack on American Free Enterprise System. The Powell Memorandum. U.S. Chamber of Commerce, 1971.

Rabito F, White L, Shorter C. From Research to Policy: Targeting the Primary Prevention of Childhood Lead Poisoning. *Public Health Reports*, 119:271-278. 2004.

Raphael D. Health inequities in the United States: prospects and solutions. *Journal of Public Health Policy*. 21(4): 394-427. 2000

Rappaport J. Terms of empowerment/exemplars of prevention: toward a theory for community psychology. *American Journal of Community Psychology*, 15: 121-148. 1987.

Rawls J. *A Theory of Justice*. Harvard University Press: Cambridge, MA. 1971.

Redman E. *The Dance of Legislation*. University of Washington Press: Seattle. 2000.

Rein M. *Social Science and Public Policy*. Penguin: New York. 1976.

Reisman J, Geinapp A, and Stachowiak S. *A guide to measuring advocacy and policy*. Organizational Research Services for The Annie E. Casey Foundation: Baltimore, MD. 2007.
[Available at www.organizationalresearch.com]

Reisman J, Geinapp A and Stachowiak S. *A handbook of data collection tools: Companion to "A guide to measuring advocacy and policy."* Organizational Research Services for The Annie E. Casey Foundation: Baltimore, MD. (2007).
[Available at www.organizationalresearch.com]

Rose G. Sick Individuals and Sick Populations. *International Journal of Epidemiology*, 14(1):32-8. 1985.

Rose G. *The Strategy of Preventive Medicine*. Oxford University Press: New York. 1992.

Rosen G. *A History of Public Health*. Johns Hopkins University Press: Baltimore. 1993.

Rosenbaum S. The Impact of US Law on Medicine as a Profession. *Journal of the American Medical Association*, 289:1546-56. 2003.

Rosenberg MB. *Nonviolent Communication: A Language of Life* (2nd ed.). PuddleDancer Press: Encinitas, CA. 2003.

Rothman KJ, Poole C. Science and Policy Making. *American Journal of Public Health*, 75(4):340-1. 1985.

Runyan CW. Back to the Future: Revisiting Haddon's Conceptualization of Injury Epidemiology and Prevention. *Epidemiology*, 25:60-64. 2003.

Runyan CW. Using the Haddon Matrix: Introducing the Third Dimension. *Injury Prevention*, 4: 302-307. 1998.

Ryan C. *Prime Time Activism*, South End Press: Boston, MA. 1991.

Ryan W. *Blaming the Victim*. Vintage Books: New York. 1976.

Sagan C. *The Demon-Haunted World: Science as a Candle in the Dark*. Random House: New York. 1995.

Satcher D. CDC's First 50 Years: Lessons Learned and Relearned. *American Journal of Public Health*, 86(12):1705-8. 1996.

Shaw R. *The Activists Handbook*. UC Press: Berkeley, CA. 2001.

Shultz J. Research and Analysis: Advocacy by Fact, Not Fiction (pp. 83-95). *The Democracy Owners' Manual, A Practical Guide to Changing the World*. Rutgers University Press: New Brunswick, NJ. 2002.

Simpson HM. The evolution and effectiveness of graduated licensing. *Journal of Safety Research,* 2003;34:25-34.

Smith B, Matheson K, and DiJulio S. *eNonprofit Benchmarks Study: Measuring Email Messaging, Online Fundraising, and Internet Advocacy Metrics for Nonprofit Organizations*. M+R Strategic Services and the Advocacy Institute: Washington, DC. 2006. [Available at www.e-benchmarksstudy.com]

Snyder H, Yoshiro C, Holton R. 2002. *Getting Action: How to Petition Government and Get Results*. Available as a PDF for download at: http://www.consumersunion.org/other/g-action1.htm

Snyder H, Oshiro C, with assistance from Iverson M. *Advocating for Change: Understanding How to Impact Health Policy*. Los Angeles: Health ExChange Academy of the Center for Healthy Communities of the California Endowment; 2006.

Snyder H, Oshiro C, with assistance from Iverson M. *Advocating for Change: Persuading Decision Makers to Act for Better Health*. Los Angeles: Health ExChange Academy of the Center for Healthy Communities of the California Endowment; 2006.

Stall S, and Stoecker R. Community organizing or organizing community? Gender and the crafts of empowerment. *Gender and Society*, 12: 729–756. 1998.

Starr P. *The Social Transformation of American Medicine*. Basic Books: New York, 1982.

Stone D. *The Policy Paradox: The Art of Political Decision Making*. WW Norton and Company: New York. 2001.

Syme, SL. Reducing racial and social class inequalities in health: The need for a new approach. *Health Affairs*, 27(2): 456-459. 2008.

Tallacchini M. Before and Beyond the Precautionary Principle: Epistemology of Uncertainty in Science and Law. *Toxicology and Applied Pharmacology*, 207(2 Suppl): 645-51. 2005.

TCC Group. "The Advocacy Core Capacity Assessment Tool." 2007. [This is an addendum tool to TCC Group's Core Capacity Assessment Tool (CCAT), available at www.tccccat.com, which presents an assessment of a nonprofit organization's organizational capacity. The Advocacy CCAT builds on the broader CCAT by incorporating key organizational effectiveness measures that are unique or particularly important for policy and advocacy organizations.]

Tesh S. *Hidden Arguments: Political Ideology and Disease Prevention Policy.* Rutgers University Press: New Jersey. 1998.

Teret SP. Litigating for the public's health. *AJPH* 1986; 76:1027-9.

Teret SP. Policy and Science: Should Epidemiologists Comment on the Policy Implications of Their Research? *Epidemiology*, 12:374-5. 2001.

Teret SP, Michaelis AP. Litigating for Native American Health: The Liability of Alcoholic Beverage Makers and Distributors. *Journal of Public Health Policy*, 26:246-59. 2005.

Tervalon M and Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, 9(2):117-25. 1998.

Tesh S. Miasma and "Social Factors" in Disease Causality: Lessons from the Nineteenth Century. *Journal of Health Politics, Policy and Law*, 20(4):1001-24. 1995.

Tocqueville, A. *Democracy in America*. Sever and Francis, 1863

Turnock BJ. *Essentials of Public Health*. Jones and Bartlett. 1996.

Tye L. *The Father of Spin: Edward L. Bernays and the Birth of Public Relations*. Crown Publishers, Inc.: New York. 1998.

Vernick JS, Mair, JS, Teret SP, Sapsin JW. Role of litigation in preventing product-related injuries. *Epidemiologic Reviews* 2003; 25:90-98.

Vernick JS, Teret SP, Webster DW. Regulating firearm advertisements that promise home protection: A public health intervention. *JAMA* 1997; 277(17):1391-1397.
AJPH 1986; 76:1027-9.

Virchow R. The Charity Physician, Medizinische Reform 1848; No. 18, November 3. In Virchow, R. (1848/1985). *Collected Essays on Public Health and Epidemiology*. Cambridge, UK: Science History Publications, p. 33.

Wallack L. Letter to the Editor. *Health Education Quarterly*, 14(4): 383-5. 1987.

Wallack L, Dorfman L, Jernigan D, and Themba M. *Media Advocacy and Public Health: Power for Prevention*. Sage Publications: Newbury Park, CA. 1993.

Wallack L, and Lawrence, R. Talking about Public Health: Developing America's Second Language. *American Journal of Public Health*, 95(4):567-570. 2005.

Wallack L, Woodruff K, Dorfman L, and Diaz, I. *News for a Change: An Advocates' Guide to Working With the Media*. Sage Publications: Thousand Oaks, CA. 1999.

Wallerstein N, and Bernstein E. (Eds.). Community empowerment, participatory education, and health. *Health Education Quarterly*, 21:141–148. 1994.

Wechsler R, and Schnepp T. *Community Organizing for the Prevention of Problems Related to Alcohol and Other Drugs*. Marin Institute: San Rafael, CA. 1993.

Weiss C. *Evaluation* (2nd ed.). Prentice Hall: Upper Saddle River, NM. 1998.

Will G. No One is Responsible for Anything (Op ed). *San Francisco Chronicle*, A25. July 7, 1998.

Wilkinson R.G. *Unhealthy Societies: The Afflictions of Inequality*, Routledge: London. 1996.

Wing K, Mariner W, Annas G, and Strouse D. *Public Health Law*. LexisNexis/Matthew Bender.

Winslow CEA. The Untilled Fields of Public Health. *Science*, 51:30. 1920.

W.K. Kellogg Foundation. *The W.K. Foundation Evaluation Handbook*. Author: Battle Creek, MI. 1998. [Available at www.wkkf.org]

World Health Organization. *Health Promotion Glossary*. Division of Health Promotion, Education and Communications (HPR) Health Education and Health Promotion: Geneva. 1998.

World Health Organization Social Determinants of Health report http://www.who.dk/document/e81384.pdf

Zimmerman M. Empowerment Theory: Psychological, Organizational and community levels of analysis. In ESJ Rappaport (Ed.) *Handbook of Community Psychology* (pp. 43-63). Kluwer Academic/Plenum Publishers: New York. 2000.

Published Advocacy Case Studies

The California Endowment "Banning Junk Food and Soda Sales in the State's Public Schools." October 2006. PDF available at http://www.calendow.org/reference/publications/pdf/npolicy/61024_CAE_BanningJunkFood7.pdf.

Dean, R. Moving from Head to Heart: Using Media Advocacy to Talk about Affordable Housing. *Issue* 16, Berkeley Media Studies Group, 2006. PDF available at http://www.bmsg.org/pdfs/Issue16.pdf.

DeJong, W. MADD Massachusetts Versus Senator Burke: A Media Advocacy Case Study. *Health Education Quarterly* August 1996; 23(3):318.329.

Farquhar S, Patel N, Chidsey M. Preventing injustices in environmental health and exposures. In Cohen L, Chavez V, Chehimi S. *Prevention is primary: strategies for community well-being*. Jossey-Bass;2007.

Harr J. *A Civil Action*. New York, NY: Vintage Books;1996.

Jernigan D, Wright P (eds.). *Making news, changing policy: case studies of media advocacy on alcohol and tobacco issues*. Center for Substance Abuse Prevention. Washington, DC: USDHHS, 1994.

Pertschuk M. *Smoke in their Eyes: Lessons in Movement Leadership from the Tobacco Wars*. Nashville, TN: Vanderbilt University Press;2001.

Petersen D, Minkler M, Vásquez VB, Baden AC. Community-Based Participatory Research as a tool for policy change: a case study of the Southern California Environmental Justice Collaborative. *Review of Policy Research*. 2006; 23:339-352.

Pillsbury, B., Coeytaux, F., Johnston, A.. From Secret to Shelf: How Collaboration is Bringing Emergency Contraception to Women, Pacific Institute for Women's Health, November 1999.
PDF available at: http://www.piwh.org/pdfs/ec_report.pdf.

Seevak, A. Oakland Shows the Way: The Coalition on Alcohol Outlet Issues and Media Advocacy as a Tool for Policy Change. *Issue* 3, Berkeley Media Studies Group, 1997. PDF available at: http://www.bmsg.org/pdfs/Issue3.pdf.

Teret SP, Alexander GR, Bailey LA. The passage of Maryland's gun law: data and advocacy for injury prevention. *J Public Health Policy*. 1990;11:26-38.

Vásquez VB, Minkler M, Shepard P. Promoting environmental health policy through Community Based Participatory Research: A case study from Harlem, New York. *J Urban Health*. 2006;83:101-110.

Wagenaar AC. Research affects public policy: the case of the legal drinking age in the United States. *Addiction*. 1993;88(Supplement): 75S-81S.

Wallack, L. The California Violence Prevention Initiative: Advancing Policy to Ban Saturday Night Specials. *Health Education & Behavior* 26(6): 841-857, December 1999.

Wang, Caroline. Photovoice: A participatory action research strategy applied to women's health. *Journal of Women's Health* 1999;8(2):185-192.

Wang C, Yuan YL, Feng ML. Photovoice as a tool for participatory evaluation: The community's view of process and impact. *Journal of Contemporary Health* 1996; 4:47-49.

Wang, CC, Cash, JL, and Powers, LS. Who knows the streets as well as the homeless? Promoting personal and community action through Photovoice. *Health Promotion Practice* 2000; 1(1):81-89.

Wohlfeiler D, Ellen JM. The limits of behavioral interventions for HIV prevention. In Cohen L, Chávez V, Chehimi S. *Prevention Is Primary: Strategies For Community Wellbeing*. Jossey-Bass, 2007.

Wohlfeiler D. Community organizing and community building among gay and bisexual men: The STOP AIDS project. in Minkler M, ed. *Community Organizing and Community Building for Health*. New Brunswick, NJ: Rutgers University Press;1997.

Woodruff, K. Alcohol Advertising and Violence Against Women: A Media Advocacy Case Study. *Health Education Quarterly* 23(3):330-345, August 1996.

Books with Advocacy Case Studies

Chapman, S. Case studies in public health media advocacy. Chapter 4 in Simon Chapman and Deborah Lupton, *The Fight for Public Health: Principles and Practice of Media Advocacy*. London: BMJ Publishing Group, 1994.

Cohen L, Chávez V, Chehimi S. *Prevention Is Primary: Strategies For Community Wellbeing*. Jossey-Bass, 2007.

Corburn J. *Street Science: Community Knowledge And Environmental Health Justice*. Cambridge, MA: MIT Press;2005.

Montgomery, K. (1989) *Target: Prime Time, Advocacy Groups and the Struggle over Entertainment Television*. New York: Oxford University Press.

Minkler M, ed. *Community Organizing and Community Building for Health*. New Brunswick, NJ: Rutgers University Press;1997.

Ryan, C. *Prime Time Activism*, Boston, MA: South End Press, 1991.

Shaw, R. *Reclaiming America: Nike, Clean Air, and the New National Activism*. Berkeley: University of California Press, 1999.

Themba, M. *Making Policy Making Change: How Communities are Taking the Law Into Their Own Hands*. Berkeley, CA: Chardon Press, 1999.

Wallack, L, Dorfman, L, Jernigan, D, and Themba, M. *Media Advocacy and Public Health: Power for Prevention* Newbury Park, CA: Sage Publications, 1993.

Wallack L, Woodruff K, Dorfman L, and Diaz, I. *News for a Change: An advocates' guide to working with the media*, Thousand Oaks, CA: Sage Publications, 1999.