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Crafting Richer Public Health Messages for A Turbulent Political Environment

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Public health leaders are now probing to find better ways to convey our messages in this turbulent political environment. In a prior Management Moment column,[1] we introduced the idea of using some of the framing concepts of Moral Foundations Theory (MFT) to craft richer stories for public health leaders to appeal to broader audiences. In this article, we return to this topic in light of recent events and in the hope that we might enhance our ability to focus our attention to the needs of those communities in despair that are feeling left behind by economic stagnation and a government that seeks to serve them.[2]

From a Political Lens to a Public Health Focus

It is easy for public health leaders to become consumed with the ongoing political and resource shifts taking place in public health and health care. However, it is also clear that public health at all levels is simultaneously wanting to engage more deeply and meaningfully with our communities of all ethnicity and socioeconomic status who are burdened by low-ranking determinants of health. This commentary is not directed toward the overheated media froth of political acrimony. Rather, we advocate for a deeper conversation about how public health can better reach out with richer messages to our communities (and policy makers) in order to accomplish meaningful law and policy change that addresses the palpable pain and despair that is at hand.

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The authors declare no conflicts of interest.

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DOI: 10.1097/PHH.0000000000000610

Building Upon the Five Essential Public Health Law Services

Public health law and policy drive the provision of public health services toward those in greatest need; hence, crafting richer messages is essential to shaping laws and policies. Creating richer stories is central to bolstering the systems approach depicted in the framework of the Five Essential Public Health Law Services,[3] particularly with respect to the 3 middle circles of designing legal solutions, helping engage communities and build political will, and support for enforcing and defending legal solutions (Figure 1).

Public health does well in marshaling expertise, evidence, and community experience to develop new, plausible ways to use law to improve public health. Greater focus on the determinants of health inevitably leads us to think about the laws that structure the status quo and the reforms that can address pervasive inequity and declining social mobility. The Five Services framework should draw new interdisciplinary attention to aspects of legal change that public health has not excelled at.

Contrary to the image called to mind by cities such as New York, most state and especially local health departments do not have the legal resources to develop policy ideas into strong legal form or, as importantly, to defend them from expensive legal challenges. Most legal innovations in health are too slow to be evaluated, if they are evaluated at all. And, when public health takes its evidence and expertise into the political realm—when the effort is made to convince lawmakers and the public to adopt new policies—we still tend to speak in narrow terms of lives saved, harms prevented, costs avoided. We are still, even in our storytelling, too reflexively reliant on science.

Moral Foundations Theory Assists in Crafting Messages to Reach a Broader Audience

Public health has tended to frame its policy arguments and legal foundations through the lens of liberal values for the last few decades. Opportunities are missed because public health hesitates in recognizing

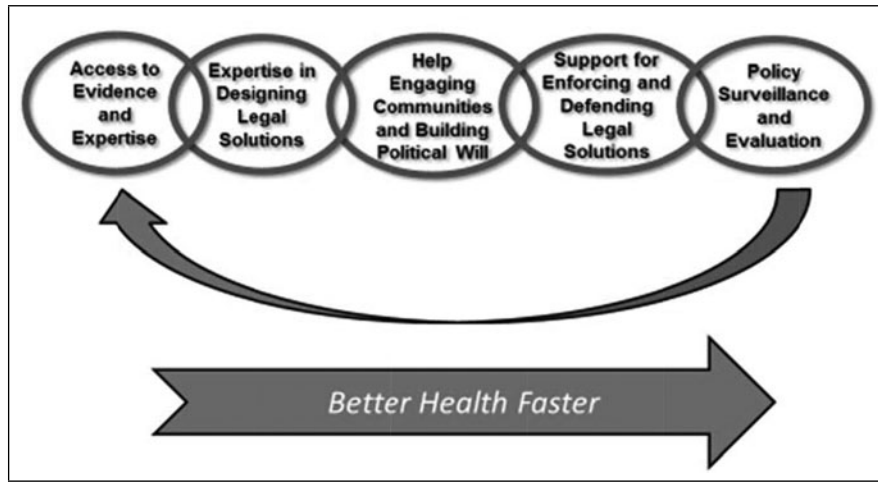

FIGURE 1 The 5 Essential Public Health Law Services

how to frame our messaging in a richer way that appeals to a broader spectrum of moral concerns. We argue that, particularly in these turbulent times, public health needs to examine more carefully how to frame its messages. Moral Foundations Theory suggests that 6 intuitive moral values shape the way in which the public considers a range of issues. Historically, public health leaders (and others) have relied on the 3 "liberal-favored" values of *Care, Liberty, and Fairness* to the exclusion of the values of *Loyalty, Authority, and Sanctity* (Figure 2). To reach a broader audience, including those communities in pain, we have advocated that messages be crafted using the full range of values that emphasize preservation of the institutions and traditions that sustain a moral community. Clearly, public health must expand our audience and thereby enhance support for the laws and policies needed to promote the public's health.

FIGURE 2 Components of Moral Foundations Theory. Adapted with permission

Jonathan Haidt's theory and data (and the data produced by other researchers using MFT), along with the underlying divergence shown between liberal/conservative values, can help those who focus on public health to be better advocates. The claim that "intuitions come first, reasoning second"[4] is enough of a powerful scientific basis for changing how we tell stories: if our messages don't initially trigger favorable intuitive responses, they will be unheard no matter how rational and well-crafted.

Although Haidt's specific categories may ultimately fail the test of time and replication, intuitions clearly seem to differ in ways that reflect personal experience and socioeconomic position. These differences must be probed, understood, and addressed by persuaders. Haidt gives us useful tools for exploring these differences in intuitions, both in ourselves and in our messaging targets.

Three North Carolina Examples of Crafting Richer Messages About Our Communities in Pain

Since our previous column, the coauthors have been frequently asked for specific examples and/or alternative approaches for enriching messaging that may be useful for practitioners in this new environment. We now present 3 different approaches from North Carolina (NC) (currently a very politically divided state) that illustrate some ways of addressing our communities in pain. We believe that there are many other examples in our nation that need to be identified, collected, explained, and shared within our public health practice community.

Example 1: Advocating for needle exchange in a battleground state

A recent NC example is drawn from a successful campaign legalizing needle exchange enacted by a conservative state legislature.[5] Advocates of needle exchange found common ground by appealing to the MFT values of *Care, Loyalty Authority, and Sanctity.*

A decade of needle exchange efforts with legislators, law enforcement, and political power players was already in place; however, all previous appeals had been blocked by typical knee-jerk rejections. When the disastrous opioid/heroin epidemic exploded, advocates of needle exchange understood the implications for public health, communicable disease, substance abuse, and health system dynamics. They also understood the need to reframe language for conservative lawmakers, emphasizing the economic impact, rising death counts, and adverse effects on families in the legislator's conservative home districts. Families were in pain, and many legislators personally knew and *Cared* about constituents that were affected.

The NC Harm Reduction Coalition, together with the substance use recovery community and public health experts, guided legislators by harnessing atypical partnerships with law enforcement, medical professionals, and respected community leaders. Conservative lawmakers were able to adhere to their traditional stance of being tough on crime and of having an aversion to degradation of the human body, both significant moral foundations in conservative communities. The advocacy process focused on preserving the values of sound economics, respect for law (*Authority*), and moral traditions of compassion for families within their communities (*Care, Loyalty, and Sanctity*).

An enhanced moral credibility for positive public messages emerged, and the irrefutable cost savings resonated with NC legislators, culminating in the 2016 authorization of sterile needle exchange programs.

Example 2: Using GIS mapping techniques to identify "communities in pain" and engage health care systems

Haidt states that the overarching priority in the conservative moral matrix is to preserve the institutions and traditions that sustain a moral community. This implies that people really do care about their communities, not just their self-interest, and may favor policies that might be disadvantageous to them personally if they believe it is good for the larger entity to which they belong. Such group *Loyalty* can also serve as a motivator to do something to interrupt conditions seen as undermining the cohesiveness and common good of the community.

UNC researchers have recently discovered that the use of interactive GIS mapping techniques of determinants of health at the census tract level is a very powerful tool to identify specific troubled neighborhoods and then promote collective response. This GIS tool helped catalyze an unexpected partnership among 2 major health care systems in Charlotte, together with the local public health department and community organizations, to better identify and target interventions to the most troubled neighborhood located directly underneath the landing path at Charlotte International Airport.[6]

Because of improved software and online access to determinants of heath data sets, advocates have the flexibility to optimally frame the scope and context of the community needing attention. This visualization of determinants of health on interactive maps can trigger people's concern for their communities. Advocates in Charlotte were able to take advantage of the MFT value of citywide community *Loyalty* to address the issue that was undeniably illuminated.

What is happening underneath airliners landing in Charlotte is a 21st-century descendant of the "point map" that John Snow first used to identify the source of the London cholera outbreak and build political consensus to shut down the Broad Street pump—years before Pasteur and Koch described germ theory for infectious disease.

This Charlotte example mapping the determinants of chronic disease makes visible connections that can trigger the appeal to our *Loyalty* to those whom we did not realize we were linked. This synapse requires not just abstract aggregate "need"—more likely to focus on *Fairness* and *Caring*—but also the accurate presentation that these are people to whom we share *Loyalty*. They … Are … Us.

Example 3: Faith-based health outreach can foster conversations based on the full range of moral values

Today in North Carolina, working class white men and their families are experiencing the wicked results of jobs and social position not entirely different from those that their African American peers lived with for many decades. Dr John Hatch of the University of North Carolina developed in the 1980s public health strategies with the predominantly African American General Baptist State Convention that are now finding relevance to the predominantly white NC Baptist Convention. Even in these times of political divisiveness, there are now increasing examples of white Baptist churches and African American Baptist churches

working together at the ground level on faith-health projects.

These approaches build on the social networks that can be trusted (*Loyalty*), and not just to be *Caring* among themselves but also to convey newly relevant scientific knowledge for prevention and management of chronic disease blending the dual authority of faith and science. Artful alignment of traditional clergy and faith roles lends the value of *Sanctity* to engage the sensitive dynamics of despair that often trigger negative health patterns as traditional as smoking and novel as opioids.

The Wake Forest Baptist Health system has explained to its conservative and liberal partners its motivation in building new structural relationships between public health, hospitals, and faith networks—black, white, and brown—in small town and rural counties where the faith networks are often the dominant social structure. This looks different in the flat, mostly black Eastern counties of the state than in the mostly white mountains or small urban areas with significant Hispanic neighborhoods. Religious networks help connect those who trust them, which extends well beyond those who regularly attend their services, to the health services that would otherwise not be trusted or accessible for reasons Haidt would expect.

Religious networks in this space function as bridges to the "other" including the social groups of different race, now actively learning from each other. This bridging includes those actively stigmatized such as the undocumented Hispanics. The FaithHealthNC networks in Winston-Salem bridge police, hospital, sheriff, and city authorities to extend highly visible identification and hospitality with faith representatives from across the spectrum, expanding the cover of faith as a proxy for trust and L*oyalty* to values that transcend traditionally narrow lines of language and ethnicity. The local EMS service parks a van and does health checks while people wait in line.

Conclusion: Look Deeper and Go Local

In this turbulent political environment, it is important to stay mindful of the pressing reality that we in public health need to craft richer messages that resonate with *all* our communities experiencing pain and despair who are clearly feeling left behind by our systems. In our previous column, we found that MFT gives us important clues about messages that resonate at a deeper level, particularly with respect to using the intuitive moral values of *Loyalty* and *Sanctity*.

In the coming years, we can anticipate less emphasis on the big, federal, overarching funding streams and more focus on the role of state/local governments doing granular, community-driven initiatives. One guiding principle that can help suggest best practices for public health is to *look deeper and go local*, as illustrated in these 3 NC examples.

The successful NC engagement on sterile needle exchange worked in part because legislators understand that "all politics is local." It made practical sense to drill down and collectively address a complex issue on the minds of local constituents who were seeing the economic and social consequences of the drug abuse epidemic in their communities. Using interactive GIS mapping to display determinants of health at the census tract level deeply illuminated struggling Charlotte neighborhoods needing collective action. The joint health collaborations of African American and white Baptist congregations in stressed rural communities leap over political and social boundaries and speak volumes about *looking deeper and going local*.

We should all continue this joint task of identifying other examples that apply the lessons derived from Haidt's MFT framework, sharing them within our public health practice networks, and creating a larger inventory of promising ways of messaging to all our communities. This is something meaningful we in public health can do every day, regardless of the latest news feed about the ongoing political froth.

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