Culture of Health
Sentinel Community Insights

Community Narrative Related to Health, Well-Being, and Health Equity: What Frames and Influences Narrative?
About This Report

The Sentinel Communities Surveillance project began in 2016 and has been monitoring activities related to how a Culture of Health has been developing in each of 29 diverse communities around the country. The purpose of the project is to learn more about how each community is working within its own historical context and current landscape to communicate about health and well-being, develop systems that promote health, and address health equity. Information on each Sentinel Community’s work is summarized in community reports, as well as cross-community insights reports on emerging themes, including this one on what frames and influences community narratives related to health.

This report includes themes from Allegheny County, Pa.; Baltimore, Md.; Butte, Mont.; Finney County, Kan.; Granville County, N.C.; Harris County, Texas; Louisville, Ky.; Maricopa County, Ariz.; Milwaukee, Wis.; Mobile, Ala.; Monona County, Iowa; San Juan County, N.M.; Sanilac County, Mich.; Tacoma, Wash.; Tampa, Fla.; Toledo, Ohio; White Plains, N.Y.

The information in this report was obtained using several data collection methods, including key informant telephone interviews, an environmental scan of online and published community-specific materials, review of existing population surveillance and monitoring data, and collection of local data or resources provided by community contacts or interview respondents. Interviews were conducted with individuals in the community representing several organization types (for example, grassroots, government, for-profit) working in a variety of sectors (for example, health, business, education, faith-based, and environment). Information collected through environmental scans includes program and organizational information available on internet websites, publicly available documents, and media reports. Population surveillance and monitoring data were compiled from publicly available data sets, including the American Community Survey (ACS); Behavioral Risk Factor Surveillance System (BRFSS); County Health Rankings (CHR); and other similar federal, state, and local data sources.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>WHAT ARE HEALTH NARRATIVES?</td>
<td></td>
</tr>
<tr>
<td>WHY IS NARRATIVE IMPORTANT?</td>
<td></td>
</tr>
<tr>
<td>WHAT COMPONENTS SHAPE AND ADVANCE HEALTH NARRATIVE IN THE CONTEXT OF COMMUNITY CHANGE?</td>
<td></td>
</tr>
<tr>
<td>The Frames in Sentinel Community Health Narratives</td>
<td>3</td>
</tr>
<tr>
<td>HEALTH IS AN INDIVIDUAL RESPONSIBILITY.</td>
<td></td>
</tr>
<tr>
<td>WE SHOULD REVERSE ALARMING HEALTH TRENDS THROUGH INTENSIVE, FOCUSED ACTION.</td>
<td></td>
</tr>
<tr>
<td>STRENGTHENING THE ECONOMY IS A TOP PRIORITY, AND IF THERE ARE HEALTH BENEFITS, THAT IS A BONUS.</td>
<td></td>
</tr>
<tr>
<td>HEALTHY PEOPLE NEED HEALTHY ENVIRONMENTS.</td>
<td></td>
</tr>
<tr>
<td>IT’S TIME TO ADDRESS HEALTH EQUITY AND SYSTEMIC RACISM.</td>
<td></td>
</tr>
<tr>
<td>What Has Motivated Change in the Frames Used in the Health Narrative Over the Past Five Years, and What Has Changed?</td>
<td>6</td>
</tr>
<tr>
<td>CHANGES IN LEADERSHIP HAVE BEEN LINKED TO ORGANIZATIONAL SHIFTS IN HEALTH PRIORITIES</td>
<td></td>
</tr>
<tr>
<td>COMMUNITIES ARE EVOLVING ALLOCATION AND USE OF FUNDING, WHICH REFLECTS THE CURRENT AND EVOLVING NARRATIVE AROUND HEALTH.</td>
<td></td>
</tr>
<tr>
<td>NEW AND MORE DIVERSE INFLUENCERS WITH LIVED OR PERSONAL EXPERIENCES ARE BRINGING NEW HEALTH EXPECTATIONS.</td>
<td></td>
</tr>
<tr>
<td>HEALTH NARRATIVE SHIFTS ARE EVIDENT IN NEW OR RE-IMAGINED PROGRAMS AND POLICIES RELATED TO HEALTH AND WELL-BEING.</td>
<td></td>
</tr>
<tr>
<td>Barriers to Advance Frames Within Health Narratives and Translate Those Into Action</td>
<td>8</td>
</tr>
<tr>
<td>Conclusions and Implications</td>
<td>9</td>
</tr>
<tr>
<td>Glossary of Terms Used in the Report</td>
<td>10</td>
</tr>
<tr>
<td>References</td>
<td>11</td>
</tr>
</tbody>
</table>
Introduction

How a community views and prioritizes health, well-being, and health equity matters to the strategy, policy, and investment choices the community makes to improve health outcomes. In the Sentinel Communities, how leaders and organizations define and discuss health issues, including the consideration of issues such as the legacy of systemic racism, has evolved over the past five years. At the same time, these health narratives were influenced by social and political changes, expanded awareness of community health needs, and new conversations in government and in civil society. The question now is whether health narratives, which might have changed or expanded to adopt new perspectives (e.g., a greater appreciation of systemic racism), will endure and lead to practical improvements in health, or shift again based on emerging priorities within communities and society more broadly. This report describes aspects of community health narratives, with specific focus on the ways in which community health narratives are framed, what and who influences and impedes those narratives, and what appear to be linkages between narratives and community action. This report provides an initial look at predominant narratives related to health, well-being, and health equity through the environmental scan and stakeholder interviews conducted for the Sentinel Communities Surveillance Project. As such, the report offers a foundational analysis of what may be driving health narratives and outlines a path for subsequent, in-depth exploration of those factors.

WHAT ARE HEALTH NARRATIVES?

Narratives are the critical frames and resultant stories and messaging that influence and inform the way people and communities see the world (see Figure 1a and glossary of terms at end). In the context of health, these narratives are rooted in culture, history, values, experiences, and mindsets, and ultimately inform the design of systems, policies, and programs that either promote health and well-being or impede health progress.1

"AGGREGATED OVER TIME—AND FILTERED THROUGH LIVED EXPERIENCE, CULTURE AND ENVIRONMENT, AND THE ECHO CHAMBERS WHERE PEOPLE SEEK FEEDBACK AND VALIDATION—NARRATIVES INFLUENCE THE WAY PEOPLE MAKE SENSE OF THEIR SURROUNDINGS, INTERPRET INFORMATION, AND MAKE DECISIONS."2

(See https://www.metgroup.com/ideas/what-if-progress-meant-well-being-for-all/ for more information.)

Community health narratives include the frames, stories, and messages that guide community orientation and decisions about health within and across organizations and sectors. Given the diversity within communities, there are often multiple narratives at play, though some narratives may dominate the primary institutions of communities (e.g., government, businesses) and thus can have a larger influence on health policy and resource allocation decisions. Which narratives are valued and promoted within communities can be shaped by factors, such as history and power.

To be sure, communities are not monolithic in terms of a shared health narrative, something that has been acutely observed as communities confront a range of health challenges (e.g., HIV/AIDS, disaster response, COVID-19).3 This narrative heterogeneity is worthy of investigation because often these narratives collide in ways that make policy choices increasingly complex, particularly in determining the direction and public will behind a particular set of health interests or investments. Further, health narratives do not exist in a vacuum only focused on health, but are often representative of broader American views about issues such as equity, freedom, libertarianism, collectivism, and so forth.4,5

---

FIGURE 1A. ELEMENTS OF NARRATIVE AND THE FACTORS THAT INFLUENCE NARRATIVE FRAMES

---

WHY IS NARRATIVE IMPORTANT?
Narrative is important for health because it helps explain why communities respond to health issues in certain ways, including actions that promote or impede health progress. In the context of the COVID-19 pandemic, for instance, narratives about the value of vaccines, the presence of health inequities, and the notions of individual rights have influenced public policy response and the design of local campaigns. Narrative is not simply a public communications campaign with tag lines and short messages. It goes deeper because it builds from and incorporates community values. As such, efforts to use narrative to mobilize community changes must tackle the values, beliefs, and perspectives that underlie these narratives. As noted in recent work from the Commission to Transform Public Health Data Systems, shifting the narrative about what matters for health, and the role of systemic racism in influencing health outcomes, is key to motivating systemic and structural shifts in which public health data are collected and prioritized, how data are analyzed, and the approach to data translation and application.

WHAT COMPONENTS SHAPE AND ADVANCE HEALTH NARRATIVE IN THE CONTEXT OF COMMUNITY CHANGE?
At its core, three main components shape health narrative and narrative adoption—first the frames of the narrative, and then the influencers and actions. Taken together, these components affect how communities think about and act on health, well-being, and health equity (see Figure 1b, which builds on Figure 1a, and glossary at end).

First, it is important to capture the health frames, that is the underlying values and beliefs about what influences health outcomes, and who is responsible for those health outcomes. As noted earlier, the elements of narrative are frames and the resultant stories and messages. Health mindset, or the way that individuals or groups view health and well-being, influence these broader community frames. In addition, experiences (both lived or personal, and current events), history, culture, and values all contribute to the development of frames. For instance, beliefs about whether healthcare services or social drivers of health are more important in determining good health, or the expectation that government should have a large or small role in influencing or shaping health are all examples of frames.

However, frames alone are not enough to shape how narratives manifest in communities. The role of influencers is key as well. Further, narrative can be part of a feedback loop that connects frames and influencers with the actions that result from changed or shifted narrative. We use the term influencers to not simply reference the current view of “social media influencers,” but the broader array of influencers that lead or provoke health conversations, shape stories about health, and/or set the priorities for health in a population or community. Individuals and organizations can adopt health frames and push health dialogue in a community in a certain direction by the investments they make, the health partnerships they encourage, or the stories they share. There also can be interaction among influencers through collective leadership, such as cross-sector coalitions or partnerships among media, political leaders, and community organizations.

The relationships among these components—frames, influencers, and actions—are dynamic and nonlinear, and as noted in Figure 1b, narrative shift can link to a change in actions, such as cultural shifts, policy changes, and programmatic changes. Some actions are not only representative of the health narrative of a community or population, but, if effective, these actions can inform reshaping or modification of the predominant narrative by shifting frames and opening the door to new influencers (e.g., small grassroots organizations or cultural groups). Actions that do not work as expected with respect to improving health outcomes may curtail the existing narrative or provide an opening for new narratives and influencers. In the sections that follow, we describe some of the more common narrative frames observed in the Sentinel Communities, motivations for narrative change, and barriers to advancing health narratives and translating narratives to action.
The Frames in Sentinel Community Health Narratives

As noted above, narratives around health and well-being are often rooted in underlying values and beliefs about the causes and solutions of community challenges, as well as who is responsible for addressing these challenges. While narratives include frames and resultant stories and messaging (as noted in Figure 1a), in this report, we focus principally on the frames given that data collection focused on stakeholder interviews and an environmental scan, with limited analysis of media and storytelling. Figure 2 summarizes some of the more common frames for the health narratives represented in the Sentinel Communities. The five categories in Figure 2 are not intended to serve as a linear typology but rather to capture the dominant frames observed within and across Sentinel Communities. Given the analysis to date, we are cautious to not affirm causal links between frames and actions (described in a later section) but offer some potential benefits and/or limitations of the frame in advancing health progress. In some cases, communities have a singular, dominant frame, but in most cases, multiple frames are in play in nascent or mature forms. This was observed across Sentinel Communities and while we provide illustrative examples in the descriptions of the frames below, many communities could have been included in more than one frame.

**FIGURE 2. FRAMES SHAPING HEALTH NARRATIVES IN SENTINEL COMMUNITIES**

- **HEALTH IS AN INDIVIDUAL RESPONSIBILITY**
  - Within several Sentinel Communities, there is a strong belief that health is one’s own responsibility. Here the prevailing view is that decisions such as whether to engage in healthy behaviors, get vaccinated, or seek medical care should be left up to the individual. Residents of these communities value access to healthcare and services so that these are readily available, should residents decide to seek those services. While there may be benefits to this frame in the context of personal health choices, such frames can hinder action to address upstream drivers of health, collective action, or structural or systemic barriers at a community level. As a result, there is less emphasis on health equity. In communities in which this is the dominant frame, local solutions to improve health and well-being are focused mainly on improving access to healthcare for the individual and providing health information to guide personal decision making.

- **WE SHOULD REVERSE ALARMING HEALTH TRENDS THROUGH INTENSIVE, FOCUSED ACTION**
  - In some communities, specific crises or defining community events, such as a natural disaster or the COVID-19 pandemic, have catalyzed health frames. In others, alarming trends such as an increase in homelessness or substance abuse in the community, have contributed to a prevailing frame that health priorities should be focused primarily on addressing the community’s immediate health concerns, even if that means placing less attention and resources towards longer-term strategies to address health issues.

- **STRENGTHENING THE ECONOMY IS A PRIORITY, HEALTH BENEFITS ARE A BONUS**

- **HEALTHY PEOPLE NEED HEALTHY ENVIRONMENTS**

- **IT’S TIME TO ADDRESS HEALTH EQUITY AND SYSTEMIC RACISM**

- **HEALTH IS AN INDIVIDUAL RESPONSIBILITY.**

Within several Sentinel Communities, there is a strong belief that health is one’s own responsibility. Here the prevailing view is that decisions such as whether to engage in healthy behaviors, get vaccinated, or seek medical care should be left up to the individual. Residents of these communities value access to healthcare and services so that these are readily available, should residents decide to seek those services. While there may be benefits to this frame in the context of personal health choices, such frames can hinder action to address upstream drivers of health, collective action, or structural or systemic barriers at a community level. As a result, there is less emphasis on health equity. In communities in which this is the dominant frame, local solutions to improve health and well-being are focused mainly on improving access to healthcare for the individual and providing health information to guide personal decision making.

Because of these core values and beliefs, much of the health narrative is being shaped by the residents themselves, who reiterate messaging around individual responsibility for health. Butte, Mont., for example, has a long history as a mining town, and respondents used phrases like “rough and tumble” and “pull yourself up by the bootstraps” to describe the local mentality around health and well-being. In Mobile, Ala., limited cross-sector collaboration, few coordinated initiatives to support health, and minimal government investment in prioritizing health has contributed to an ongoing perception that health is primarily an individual responsibility. Many residents and health leaders in Monona County, Iowa, also hold a belief that health is an individual responsibility, and that poor health outcomes are a consequence of poor health choices made by individuals. In these communities, health messaging or guidance issued by government officials (e.g., value of vaccination), as a result, is often met with messages of resistance or stories to elevate the importance of individual responsibility for health from local influencers (e.g., personal rights over community benefit); these messages are then bolstered by state and national influencers who oppose what they perceive to be government overreach. This resistance has been particularly evident during the COVID-19 pandemic.

- **WE SHOULD REVERSE ALARMING HEALTH TRENDS THROUGH INTENSIVE, FOCUSED ACTION.**

In some communities, specific crises or defining community events, such as a natural disaster or the COVID-19 pandemic, have catalyzed health frames. In others, alarming trends such as an increase in homelessness or substance abuse in the community, have contributed to a prevailing frame that health priorities should be focused primarily on addressing the community's immediate health concerns, even if that means placing less attention and resources towards longer-term strategies to address health issues.
systemic or structural drivers of health that may have broader health implications. Although the frame itself may remain constant (focused on addressing immediate community need), the stories and messages, and the linked influencers and actions are likely to fluctuate significantly over time as communities jump from priority to priority. While beneficial in the short term, one potential challenge of this frame is that the community can become narrowly focused on a specific health priority, undermining broader conceptualizations of health, health equity, and systems change seen in other health narrative frames.

In these communities, primary influencers include health coalitions, healthcare providers, and health systems, who point to recent data or observed trends among their constituents or patient populations in efforts to shape the health narrative. The health narrative in Finney County, Kan., has focused on addressing specific issues like reducing teen pregnancy, tobacco cessation, substance use, and improving access to healthcare, particularly for immigrant and refugee populations. Mental health has been solidified in the health narrative in San Juan County, N.M., where groups like the San Juan Safe Communities Initiative and the new county Mental Wellness Resource Center have made seeking help for mental health issues more mainstream. In Baltimore, Md., combatting spikes in community violence and addressing concomitant trauma in residents have become cornerstones of the health narrative because of ongoing concerns around violent crime. Acute crises such as the COVID-19 pandemic and the opioid epidemic have also spurred dialogue about social isolation and mental health as part of the health narrative across Sentinel Communities.

**STRENGTHENING THE ECONOMY IS A TOP PRIORITY, AND IF THERE ARE HEALTH BENEFITS, THAT IS A BONUS.**

Due to the devastating impacts of COVID-19, many communities have put economic recovery at the top of their policy agendas. Even before the pandemic, economic revitalization and large investments to transform cities into tourist destinations or business hubs were underway, with goals related to creating walkable business districts, attractive public amenities, and connected residential and business areas. These communities emphasize livability and vibrancy, which may have resulting positive health impacts, but exist in service primarily of economic development goals. Many economic revitalization efforts also have a specific emphasis on strengthening or increasing the number of women or minority-owned businesses, which can have a positive impact on health equity. At the same time, voices of those outside of business districts and those who may have been displaced because of revitalization efforts can be marginalized and likely will not benefit from those community investments. Influencers representing those groups often have a harder time shaping health narrative within the context of economic priorities that have received heavy political and financial backing.

Health narrative here is shaped by many in business, industry, and local government, who tout health benefits of revitalization and make connections to health to entice economic activity and draw people in—companies want healthy, walkable, safe cities for employees and their families, and tourists want to visit cities that have these amenities. Messaging is around the health of the city, built environment, parks and greenways that connect businesses and increase access. For example, revitalization efforts in Tampa, Fla., have been underway for years, with goals delivered on goals of developing neighborhoods, workspaces, and housing options that prioritize wellness, reflecting the way health priorities can be integrated with economic priorities. The surrounding Westchester County has focused efforts on supporting business and leadership development in the region, particularly for women and people of color, through the development of a business enterprise program. Sanilac County, Mich., has been working to enhance the economic base of the region through vocational training, pathways to higher education, and “Welcome Home” scholarships that provide incentives for former residents to move back and begin their careers.

**HEALTHY PEOPLE NEED HEALTHY ENVIRONMENTS.**

Within some Sentinel Communities there is a strong belief that the community environment, inclusive of the built and natural environment as well as the amenities within it, influence the health of its residents. Here narratives focus on the importance of access to healthy food, safe housing, and opportunities for physical activity to promote health, as well as environmental factors such as extreme heat or toxic waste that negatively affect the health and well-being of residents. Communities that use this frame recognize that they have a responsibility to help individuals meet basic needs and make healthier choices, and often do so by investing in and expanding community resources like green spaces, affordable housing, and greater access to fresh fruits and vegetables. It should be noted that this frame can sometimes lead to siloed health messaging (e.g., healthy nutrition messaging separate from messaging about safe housing), but it does have the benefit of influencing collaboration across sectors to meet the resident needs, which can foster a more comprehensive health narrative.

In these communities, influencers like foundations, nonprofits, and public health departments have elevated the narrative connecting social determinants of health and resulting health outcomes and inequities, often using geographic (e.g., zip code) data to make the case. Other influencers in this space include coalitions and leaders of social service organizations that work to address specific needs such as access to healthy food or safe housing. For example, in Maricopa County, Ariz., the Vitalyst Health Foundation has catalyzed a shift in thinking about food insecurity and housing differently, with a focus more on risk factors and upstream causes of these outcomes through the Elements of a Healthy Community Wheel, which highlights the role of multiple sectors in improving health in the community. Health narratives in Allegheny County, Pa., embody a more holistic, social determinants of health frame, where issues related to maternal and child health, air quality, and broader environmental concerns are prioritized. In Toledo, Ohio, community leaders sought to incorporate community voice and input for the planning of a large-scale Metroparks project to ensure accessibility and benefit for all, which resulted in broad buy-in and the passage of a tax levy to support the effort.
In Granville County, N.C., significant effort has been put into revitalizing local athletic and recreational facilities and expanding a network of greenways, led by the Granville Greenways committee and integrated with the activities of the local cross-sector wellness coalition.

It’s time to address health equity and systemic racism.

Some Sentinel Communities have embraced frames related to the deleterious effect of legacy policies, historic injustices, and persistent disparities within their community. In these communities, influencers like local government, grassroots community organizations, and civil rights groups lift a health narrative that considers the role of structural racism and history in the distribution of benefits and risks to health. In other communities, new and more diverse influencers have brought attention to racial inequities and catalyzed new narrative frames through their messaging, coalition building, and local investments. While it is unclear if this frame will lead to durable systemic changes, communities that have framed health through the lens of systemic racism attempt to address root causes and the role of policy (historic and current decision-making) and systems change in reversing health inequities and advancing health equity. Milwaukee, Wisc. was one of the first cities to declare racism a public health crisis and conversation has deepened beyond health disparities to tackle the city’s legacy issues of racial and economic discrimination more squarely. The narrative in Harris County, Texas has recently shifted to one that recognizes the role of systemic racism in determining health and social outcomes, sparked by a recent health disparities study and the disproportionate impact of the COVID-19 pandemic on residents of color. The narrative in Louisville, Ky., shifted in 2020 to name racism and poverty as explicit drivers of inequity. Documents like A Path Forward, published by a group of influential Black leaders in 2021, lay out a series of commitments, investments, and actions to extend the health narrative and create meaningful change in Louisville. In Tacoma, Wash., messaging of the local health department together with the city of Tacoma, nonprofits, the private sector, major healthcare systems, and the local school system, acknowledges the role of systemic racism in achieving health and social equity in the community. Grassroots leaders are powerful influencers in Louisville and Tacoma, providing examples of collective leadership.
What Has Motivated Change in the Frames Used in the Health Narrative Over the Past Five Years, and What Has Changed?

Over the past five years, there have been some shifts in the frames used in health narratives across many Sentinel Communities, although there was variation in the extent to which such change occurred. Changes in leadership, new (and more) influencers, and experiences that have shifted the health mindset within communities appear to be part of the motivation for such change. Actions can, in part, be linked to these narrative shifts, though more analysis would be needed to specifically assess the causal links between shifts and actions. As noted in Figure 1b, shifts in frames can influence shifts in culture, policies, and programs, but these pathways are feedback loops and can be nonlinear.

CHANGES IN LEADERSHIP HAVE BEEN LINKED TO ORGANIZATIONAL SHIFTS IN HEALTH PRIORITIES

In some communities, the election of new leaders brought with it new or renewed initiatives, priorities, and investments. Beyond agenda setting, newly elected officials may further shape the health narrative through shifts in executive priorities, the establishment of new departments or offices, or commissioned studies to examine an issue of importance.

- In Milwaukee, the mayor removed the head of the Equal Rights Commission and created an Office of Equity and Inclusion in 2020. A resolution was passed for this office to audit all city departments on racial equity. Milwaukee Common Council members asked the mayor to ensure that equity and inclusion was considered in the ARPA fund allocations. In 2021, the Office of Equity and Inclusion fielded a public survey to capture community input on how to prioritize the ARPA funds.

- The Maricopa County Department of Public Health leveraged the healthy environments frame, added 30 new positions to the health department, and invested $5 million to address homelessness and continued rental and utility assistance, key social determinants of health.

- In Butte, where health is largely seen as an individual responsibility, residents are increasingly concerned about homelessness, substance abuse, and mental health issues that solutions focused on individual behavior change and access to existing services have failed to address. This has led to calls from some local influencers for new investments and systems change.

- Finney County has traditionally focused efforts on addressing emerging or acute health concerns in the region. However, there is a growing recognition of the importance of healthy environments, and investments have recently been made in new parks, trails, and public facilities. Community gardens have also been considered in some housing developments.

- Sanilac County has not only invested in building local workforce capacity and strengthening the economy, but residents have also renewed the local tax millage fund to support organizations addressing domestic violence, sexual assault, and homelessness—emerging areas of concern in the region.

COMMUNITIES ARE EVOLVING ALLOCATION AND USE OF FUNDING, WHICH REFLECTS THE CURRENT AND EVOLVING NARRATIVE AROUND HEALTH.

Shifts in health narrative have resulted in new funding considerations and the allocation of resources to address health and well-being. Some of this is in response to concerning health trends, while others represent new recognition of what influences health outcomes. Because communities often have more than one narrative frame, it is not uncommon to see communities investing in solutions that seemingly contradict their prevailing narrative. In some cases, such investments may be a signal of narrative changes to come, while in others, the narratives and corresponding actions are considered complementary (e.g., prioritize economic recovery while still wanting to address emerging health trends, particularly if it may undermine such recovery).
NEW AND MORE DIVERSE INFLUENCERS WITH LIVED OR PERSONAL EXPERIENCES ARE BRINGING NEW HEALTH EXPECTATIONS.

Efforts to ensure diverse representation in health-related decisions has expanded opportunities for influencers to shape the health narrative of the community, or at least question dominant health narratives. Because these new influencers may reflect different frames and lived experiences, the stories they share have the potential not only to shape the mindset and frames of others in the community but may spur attention and action to address health and well-being in new ways. In some communities, the introduction of new influencers has not been due to an appreciation of their specific health views, but spurred from general concerns over government failures and stalled progress on issues like racial injustice and racial equity.

- **Toledo** leveraged the frame of health equity to form a Racial Equity and Inclusion Council comprised of community members and leaders working to combat systemic racism and disparities within multiple sectors.

- **White Plains** Hospital, a local influencer of community health priorities, recognized that their prior top-down approach was ineffective and has shifted the way they work to ensure that initiatives are being developed with greater community input and alignment.

HEALTH NARRATIVE-shifts are evident in new or re-imagined programs and policies related to health and well-being.

In some cases, health narratives can be linked to how health programs and policies are designed. Evidence of this in Sentinel Communities is seen both in the development of new policies and programs, as well as a re-examination of existing challenges and efforts through a new lens.

- **In Harris County**, the frame of health equity has been key to deepening a focus on social determinants of health, particularly through the establishment of the Greater Houston Coalition for Social Determinants of Health (later, the Health Equity Collective). Stakeholders have described how the coalition wrapped an equity-based framework around known health issues and priorities, including lack of access to transportation, poverty and basic needs, housing challenges, and educational opportunities, not only in discussions within but also across organizational programming.

- **In Baltimore**, concerns about alarming health trends related to trauma have been motivating programmatic and policy changes. The city has increasingly acknowledged the role of trauma in poor health and health disparities. Language in the 2020 Elijah Cummings Healing City Act highlights the role of city employees, public safety, and emergency services personnel in trauma response, legislating training and new protocols for programming.
Barriers to Advance Frames Within Health Narratives and Translate Those Into Action

There are promising ways that health narratives appear to be influencing concrete health actions. However, it can be challenging to translate the frames within these narratives into actions that clearly result in positive health outcomes. At times, health frames such as individual responsibility and healthy environments conflict and have consequences for health investments. At other times, barriers such as political will and governance can impede the durability of certain health frames. Further, some frames such as those that consider health equity, attempt to address legacy and systemic issues (e.g., racism), while other frames might be considered race-neutral. Table 1 provides a summary of key barriers, with illustrative examples.

<table>
<thead>
<tr>
<th>BARRIERS</th>
<th>ILLUSTRATIVE COMMUNITY EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pervasive values related to individualism</td>
<td>When faced with disproportionate impacts of COVID-19 among those with chronic diseases, communities with pervasive individual mindsets, such as Mobile, reaffirmed the importance of individuals taking responsibility for their own health.</td>
</tr>
<tr>
<td>Polarization and challenges to creating shared values</td>
<td>In San Juan County, cultural and political differences have presented barriers to shared dialogue and action around health and well-being. Respondents described that political polarization has increased in recent years, and plays a role in conversations about equity, immigration, relationships with tribal nations, the role of local law enforcement, renewable energy, gun ownership/control, and other pressing issues in the community.</td>
</tr>
<tr>
<td>Governance challenges, including funding silos</td>
<td>In Butte, there is a concern over state level budget cuts to health and human services, including suicide prevention funds. This concern about acute health issues has highlighted how human services are a “band-aid” for larger, systemic issues, but constant risk of financial cuts impedes that broader health frame to take root.</td>
</tr>
<tr>
<td>Willingness to take on the issue of racism and other sources of inequity</td>
<td>Toledo had considered declaring racism a public health crisis, but this effort lost traction when set alongside the COVID-19 response. The city also had a Diversity, Equity, and Inclusion Board, but stakeholders noted that it became dysfunctional. Given these challenges and lack of strong political will, many stakeholders reported being skeptical that current activities to address inequity will translate into meaningful change.</td>
</tr>
</tbody>
</table>
Conclusions and Implications

The analysis of health narratives in Sentinel Communities reveals important insights about what ideas and values are influencing and framing the positioning and priority of health in community discussions. Five distinctive frames are in play in these communities, which stretch from personal responsibility to episodic awareness of health trends, to deeper analysis of root drivers of health. At times, these frames can coexist, as efforts to address acute health concerns can be the tipping point for broader health actions. At other times, these frames can sideline certain solutions because of the competing priorities each offers. While it appears that a personal responsibility frame alone limits the ability to address health equity and social and historical factors influencing health outcomes, the other four frames can offer some value in inviting new collaborators and narrative influencers into community health discussions. However, it can be challenging to form and advance new frames for health progress when these new or less highlighted frames are “crowded out” by dominant or legacy health frames.

Directly linking health narratives to policy or programmatic choices can be difficult given the number of factors that move a frame into messaging and ultimately shape government action and the methodological challenges to establish causation. However, the frames and supporting influencers to advance a health narrative can be a powerful tool in how government and civil society leadership makes its case and seizes opportunities, such as COVID-19, to accelerate new health initiatives. It is important to consistently monitor and evaluate the evolution of these health frames, who is advancing those frames, and how the fuller narratives move across influencers given the barriers noted earlier. It will necessitate richer study of the resultant stories and messages that come from the health frames and how those are received. This will require deeper analysis of the culture, values, and ideologies behind each frame and how each exists within larger “non-health” community narratives.
Glossary of Terms Used in the Report

**Actions:** in the context of this report, the outcomes of narrative change, such as cultural shifts, policy changes, program changes

**Culture:** sharing and alignment of beliefs, attitudes, values, and actions across a set of individuals, organizations, and decision environments (e.g., where policies or laws are made) (from *Building a National Culture of Health*, Chandra et al., 2016)

**Experiences:** events or encounters—can relate to lived or personal experiences and/or current events or experiences in a community

**Influencers:** individuals, organizations, or collective leadership that lead or provoke health conversations, shape stories about health, and/or set the priorities for health in a population or community

**Frames:** underlying values and beliefs of what influences outcomes (e.g., health)

**Messages:** the articulation of the narrative frame that serves as the strategic foundation for storytelling (see [metgroup.com/narratives](http://metgroup.com/narratives))

**Mindsets:** ways that individuals and groups view a topic, such as a health and well-being (from *Drivers of Health as A Shared Value: Mindset, Expectations, Sense of Community, And Civic Engagement, Health Affairs, Chandra et al., 2016*)

**Narrative:** the critical frames and resultant stories and messaging that influence and inform the way people and communities see the world

**Stories:** accounts of experiences via oral or written tradition—“narratives can represent the aggregation of stories that we see, hear and experience” (see [metgroup.com/narratives](http://metgroup.com/narratives))

**Values:** principles or standards of behavior
References


