

Health Equity Education, Awareness, and Advocacy  
through the Virginia Department of Health  
Health Equity Campaign

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(ABSTRACT)

This study showed that health equity must be achieved through education, awareness, and advocacy. A structured program must be put in place to provide accountability towards achieving health equity within organizations, communities, cities, and states. In Virginia, the *Health Equity Campaign* was a program put in place to provide such accountability to the citizens of Virginia. This study attempted to evaluate the *Health Equity Campaign* implemented by the Virginia Department of Health Office of Minority Health and Public Health Policy Division of Health Equity in order to get all Virginians to become advocates for health equity in their organizations, communities, neighborhoods. Organizational/group leaders were interviewed in addition to surveying various staff members. This study provides a detailed description of the strength of the *Health Equity Campaign's* ability to promote education and awareness about health equity and why many participants found it difficult to transition from motivation to advocacy.

## Dedication

*“I can do all this through Him who gives me strength”*

Philippians 4:13 (NIV)

Thank You Lord for showing me that with believing in myself and in You all things are possible!

This is dedicated to my mom and dad, Velma and Glenwall Richards, my brothers and sister Asante, Asheno, and Dr. Tahshann Richards. My niece and nephew, Bailey Madison Richards and Zyon Joseph Lord, my grandmother and grandfather, Gertrude and Linus Reid. Thank you for your unchanging love, encouragement, prayers, and support. I love you with all my heart! God has truly blessed me with an amazing family!!!

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In loving memory of my grandmother, Amelia Elizabeth Campbell, my source of inspiration, hope, strength, and determination; and who always told me to try my best!

I love you!

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To the participants in this study, thank you for your time and input. May you continue to strive to make advances towards the commonwealth of Virginia.

I look ahead to the next chapter of my life with great joy and strong commitment to the promotion of health equity. My goal is a life dedicated to compassion, service, leadership, and education for all!

*“Intelligence plus character - that is the goal of true education.”*

Dr. Martin Luther King, Jr.

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## Chapter 1

### Introduction

#### The Virginia Department of Health

In a message posted on the Virginia Department of Health website, director of the Office of Minority Health and Public Health Policy, Dr. Michael O. Royster, states the words spoken by Reverend Dr. Martin Luther King Jr. over 40 years ago, “Of all the forms of inequality, injustice in health is the most shocking and inhumane” and notes, “While the health status of all Americans has improved significantly since that time, injustice in health continues to exist in the United States and in our Commonwealth” (OMHHE Director's Message, 2009). In referencing the 2008 Health Equity Report, Dr. Royster states, Health inequities exist in Virginia by socioeconomic status, race and ethnicity, gender, neighborhood and geography. Not only are the most disadvantaged Virginians at increased risk for a multitude of adverse health outcomes, but even Virginians in the middle experience poorer average health outcomes than those with the greatest level of social and economic advantage. Eliminating health inequities should be a priority for all Virginians” (OMHHE Director's Message, 2009).

The Division of Health Equity in the Office of Minority Health and Public Health Policy implemented the *Health Equity Campaign* efforts within Virginia. The *Health Equity Campaign* originated as a partnership between The National Association of County and City Health Officials (NACCHO) and California Newsreel’s award winning PBS documentary, “*Unnatural Causes...Is Inequality Making Us Sick?*”. The *Health Equity Campaign* serves to help

individuals, communities, organizations, and policymakers define, understand, and promote health equity through appropriate measure and interventions.

The Virginia Department of Health, Office of Minority Health and Public Health Policy (OMHPHP) is committed to the promotion of the initiative to advance health equity within a social justice framework while using strategies consisting of facilitating statewide town hall meetings; supporting local health districts in conducting screenings and community forums; and providing resources consisting of community action toolkits, event flyers, press releases, and fact sheets to agency partners, major stakeholders and community-based organizations (OMHHE, 2010). Michael O. Royster, MD, MPH is the Director of the Office of Minority Health and Public Health Policy. The office's mission is to advance health equity by identifying health inequities, assessing their root causes, and addressing them by promoting social justice, influencing policy, establishing partnerships, providing resources, and educating the public (OMHHE, 2010). The OMHPHP serves as Virginia's office of minority health, rural health, and primary care. The primary focus is on advancing health equity through designating medically underserved areas, improving access to quality health care, addressing barriers to rural health, focusing on community-based participatory efforts to promote health equity, and facilitating strategies which target the social determinants of health and advance social justice (OMHHE, 2010).

The primary goal of the Division of Health Equity which heads the *Health Equity Campaign* is to permanently change the conditions that produce differential health outcomes that will, over time, have a greater effect than traditional interventions. These duties are accomplished by working with stakeholders to identify approaches to eliminate health inequities

through a focus on social determinants of health and social justice, in addition to more traditional health promotion, as key strategies to eliminate health inequities that exist by socioeconomic status, race/ethnicity, geography, gender, immigrant status and other social classification. For example, questions exploring health are reframed by the division to the following to allow for a greater understanding of root causes. Examples of reframing health questions to address health equity include:

*Conventional: How can we promote healthy behavior?*

*Health Equity: How can we target dangerous conditions and reorganize land use and transportation policies to ensure healthy spaces and places?*

*Conventional: How can we reduce disparities in the distribution of disease and illness?*

*Health Equity: How can we eliminate inequities in the distribution of resources and power that shape health outcomes?* (Engagement, 2010; Equity, 2009)

Karen Reed is the director of the Division of Health Equity. She has served as the key contact and guide to the principal investigator of this study by first introducing the principal investigator to the efforts and purpose of the *Health Equity Campaign* and providing the principal investigator with a list of eligible study participants and organizations to begin recruitment for the study. Various members of the division also provided contributions in constructing a database of eligible study participants. Karen and Dr. Royster worked with the investigator on the timeline, structure, survey questions, and focus of the research keeping it in line with the goal and objectives of the division's *Health Equity Campaign*. In addition, Karen provides leadership and oversees a number of health equity related initiatives such as the

Culturally and Linguistically Appropriate Health Care Services Initiative (CLAS), Culturally Appropriate Public Health Training Series, Medical Interpreter Training Grants Program, and *Navigating the U.S. Health Care System*, a project designed to assist new immigrants, refugees, and migrants in obtaining needed health care services. Through Michael Royster, Karen Reed, and the Health Equity Specialist/CLAS coordinator, the division is focused on long-term efforts of eliminating health inequities ((Engagement, 2010; Equity, 2009).

## Problem

There is a social gradient in health that runs from top to bottom of the socioeconomic spectrum. This is a global phenomenon, seen in low, middle, and high income countries. There is a persistent and overriding problem of health inequities that exist within Virginia and within the United States. Within Virginia, health conditions, morbidity, and mortality differ among socioeconomic and racial and ethnic individuals and communities (OMHHP, 2008). The differences relate strongly to social inequities which have historically resulted in unequal opportunities to be healthy (OMHHP, 2008). The result is health inequities, which are disparities in health [or health care] that are systemic and avoidable and considered unfair (Troutman, 2006) (OMHHP, 2008). Social inequities cause a differential exposure to the social determinants of health (SDOH) which include family, community, income, education, sex, race/ethnicity, geographic location, and access to health care (Mead et al., 2008) (HHS, 2008). In fact, there is a gradient in health that follows the socioeconomic gradient, such that Virginians of higher socioeconomic status (SES), on average, live longer and healthier lives than Virginians of middle socioeconomic status, who live longer and healthier lives than Virginians of lower socioeconomic status (OMHHP, 2008).

## Purpose of the Study

The Virginia Department of Health serves a primary public health care role to make readily available to lawmakers, residents, and researchers reliable and valid health information (OMHHP, 2008). The data provided by the health department such as statistics regarding residents of low SES, as well as rural, racial and ethnic minority populations is vital to eliminating the health inequities that exist within these populations (OMHHP, 2008). The purpose of this present study was to evaluate the impact of the Virginia Department of Health Office of Minority Health and Public Health Policy (OMHPHP) *Health Equity Campaign* on various individuals and organizations within Virginia. According to the 2008 Virginia Department of Health Office of Minority Health and Public Health Policy “ Unequal Health Across the Commonwealth: A Snapshot Virginia Health Equity Report 2008”, a deliberate focus needs to be placed on both understanding and improving (through public policy strategy), the social determinants of health, and the impact in which they have on disadvantage and marginalized individuals and communities (OMHHP, 2008) Improved understanding of the policies that determine the distribution of the SDOH includes an analysis of the unintended effects of policies and the interactive effects of policies across multiple sectors (OMHHP, 2008). This study served to evaluate the *Health Equity Campaign* presentations impact on education, awareness, and advocacy of health equity in Virginia.

## Research Question

What impact has the *Health Equity Campaign* presentations had on enabling organizations and its members to incorporate a focus on health equity into their organizational policies, practices, and programs?

## Objectives

1. To determine participant satisfaction with the presentations delivered as part of the Virginia Department of Health OMHPHP *Health Equity Campaign*.
2. To determine the Virginia Department of Health OMHPHP *Health Equity Campaign*'s impact on increasing:
  - a) individual knowledge and awareness about health equity
  - b) individual and organizational advocacy and development of health equity intervention programs
3. To establish a list of recommendations for increasing knowledge, awareness, and advocacy of health equity.

## Significance of the Study

Health equity is defined as the absence of systemic disparities in health (or in the major social determinants of health) between social groups who have different levels underlying social advantage/disadvantage- that is, different positions in social hierarchy (Braveman & Gruskin, 2003). This study served to ultimately further develop the Virginia Department of Health OMHPHP *Health Equity Campaign*. By evaluating the campaign and the impact of which the campaign had on its participants, the *Health Equity Campaign* can be further used to educate and raise awareness about health equity to all Virginians, enable Virginians to take action, and as a result, help eliminate the vast array of health inequities that exist and achieve health equity in Virginia. Addressing health inequities is a necessity of great importance. In a report by the

World Health Organization Commission on Social Determinants of Health, the commission stated, “Reducing health inequities is, for the Commission on Social Determinants of Health, an ethical imperative. Social injustice is killing people on a grand scale” (*Closing the Gap in a Generation*, 2009).

#### Use of Documentaries as Educational Tools

Much like the documentary *Unnatural Causes...Is Inequality Making Us Sick?*, there are a number of documentaries used to raise awareness, knowledge, understanding, and advocacy of issues of social matter. One such documentary, *Eyes on the Prize* educates its audience on the United States Civil Rights Movement. *Eyes on the Prize* is an award-winning 14-hour television series produced by *Blackside* and narrated by Julian Bond. Through a series of interviews and historical footage, the documentary depicts the major events of the Civil Rights Movement from 1954-1985. *Blackside* is a documentary film production company dedicated to raising consciousness about America's social progress and history. Series topics range from the Montgomery Bus Boycott in 1954 to the Voting Rights Act in 1965 (Prize, 2006).

Also as similar to NACHO's collaboration with California Newsreel to promote Health Equity through “*Unnatural Causes... Is Inequality Making Us Sick?*” and the *Health Equity Campaign*, *Blackside* also manages the *National Outreach Initiative*. The *National Outreach Initiative* is a combined effort of three partners, *Outreach Extensions*, *National Black Programming Consortium*, and *Facing History and Ourselves* to promote education and awareness of the Civil Rights Movement through *Eyes on the Prize*. *Outreach Extensions* is a national consulting firm that specializes in campaigns for media projects. Its' outreach campaigns expand the impact of PBS documentaries beyond the television broadcast into the



community, and builds the capacity of community organizations to utilize media tools and resources. The *National Black Programming Consortium* (NBPC) is a non-profit media arts organization which has created and implemented the *Eyes on the Prize Black College New Media Project*, which provides grants to Historically Black Colleges and Universities to produce blogs, short movies, and podcasts that engage issues explored in *Eyes on the Prize*. *Facing History and Ourselves* promotes classroom and other discussions in regards to encouraging young people to think critically about racism, prejudice, anti-Semitism and difficult issues that divide society. *Facing History and Ourselves* provides teachers with tools and support to connect the lessons of history to the challenges of living in an increasingly interconnected world (excerpt from *Eyes On the Prize* web page (Prize, 2006)). *Facing History* has created numerous classroom study guides and lesson plans, led educator workshops, and made many national presentations as part of its' role in the *Eyes on the Prize* outreach campaign. Evan Leach, Ph.D. serves as the program evaluator for the *Eyes on the Prize* National Outreach Initiative (Prize, 2006).

Another PBS documentary, *The Forgetting*, is used as an educational tool to family members and caregivers of persons living with Alzheimer through raising knowledge and awareness about the disease. Similar to the objectives of this study, The National Center for Outreach conducted a study to assess the impact of knowledge, attitudes, and behaviors as a result of the film. The study measured the change in the understanding of Alzheimer in addition to the capacity gained to better care for someone with the disease as a result of viewing the film and outreach activities surrounding the film. This study was the first study done by the National Center for Outreach to develop an impact assessment tool to measure the impact in which PBS documentaries and related outreach activities had on local communities. The impact measures

were based on the following themes Learning/Awareness Raising, Attitude Change, and Behavioral Change. Researchers showed that as a result of the film and related outreach interventions, both education and awareness regarding caring for someone with Alzheimer's disease was significantly increased in addition to gaining an enhanced mutually effective and beneficial performance when caring for someone with the disease. Researchers also provided a list of recommendations to improve the impact of PBS documentaries and related outreach activities (Outreach, 2004).

Other documentaries addressing the issues of health equity and social justice in the United States produced by California Newsreel include "*Money Driven Medicine*", which discusses the economics and financial decision making behind the United States Health Care System, "*Brick by Brick*", about the struggle to bring desegregation in housing to a neighborhood in Yonkers, New York during the 1980's, and "*February One*", a story surrounding the 1960 Greensboro lunch counter sit-ins which evoked the Civil Rights Movement. These films are often used by professors, educators, and college and high school teachers to increase target audiences' knowledge of the Civil Rights Movement of the past, social justice issues past and present, and to motivate these individuals to take action to promote social change and equality (Newsreel, 2010).

### Delimitations

Participants in this study were comprised of individuals belonging to different groups and organizations including, health directors, nurses, community leaders, lay health workers, researchers, and clinicians. Therefore, the methods and findings of this study can be applied to a broad range of organizations and institutions at various local and statewide levels.

## Limitations

The limitations of this current study are that due to the nature of this study the time between the study and the intervention being evaluated varied significantly amongst participants. For example, some participants, both surveyed and interviewed, may have viewed the documentary and participated in presentation and surrounding activities years prior to the interview and survey, while for some it may have been only a few months since participating in the presentations. Some other limitations caused by the time in which the study took place are that many individuals who have received the presentation were no longer present in their positions due to change in administration. For some it also may have been difficult to recall and evaluate aspects of the presentations due to the time that had elapsed. Another limitation is that various participant groups viewed different scenes or may have only seen various clips of the documentary *“Unnatural Causes...Is Inequality Making Us Sick?”* during the presentations. While the VDH OMMH lead many of presentations to various groups, in some cases these individuals from these groups further lead, participated, or delivered presentations to other groups in which they were involved, creating a very complex organizational structure of participants. In addition, some individuals who have seen certain episodes during a presentation and developed an interest in watching the documentary in its entirety had taken the liberty to view the entire documentary on their own apart from the group in which the presentation was initially received, which may have influenced study surveys and interviews. The interest level of the participants may also present as a limitation. Participants, who are already involved in the health field or even the lay public who volunteer to participate in the *Health Equity Campaign*

and view the presentations, may be more receptive and understanding of health equity than the general public and those who would not volunteer their time.

## Summary

In Virginia health inequities continue to exist. In addition, there is a gradient in health that follows the socioeconomic gradient, such that Virginians of higher socioeconomic status (SES), on average, live longer and healthier lives than Virginians of middle socioeconomic status, who live longer and healthier lives than Virginians of lower socioeconomic status. The VDH OMHPHP Division of Health Equity has adapted NACCHO's *Health Equity Campaign* to raise knowledge, awareness, and advocacy to its own residents and their respective organizations and communities. The primary tool in this campaign is the educational and award winning PBS documentary produced by California Newsreel "Unnatural Causes...Is Inequality Making Us Sick?". This study was used to evaluate the ability of the VDH OMHPHP *Health Equity Campaign* to mobilize its' participants towards health equity education, awareness, and advocacy.

## Chapter 2

### Review of the Literature

#### Defining Health Equity

In their 2003 article, “Defining Equity in Health”, Braveman and Gruskin emphasize the importance of defining health equity for purposes of measurement and accountability. They define health equity as, the absence of systemic disparities in health (or in the major social determinants of health) between social groups who have different levels underlying social advantage/disadvantage- that is, different positions in social hierarchy (Braveman & Gruskin, 2003).

The World Health Organization (WHO) defines health as a state of complete physical, mental and social well being and not merely the absence of infirmity (Droese et al., 2008; Organization, 2003). The goal of the WHO is that all people have access to the highest possible level of health. This includes fairness or equity in health. In other words the goal is to have the smallest possible difference in health status between individuals and groups (Droese et al., 2008).

#### Social Determinants of Health

According to Braveman and Gruskin, inequities in health systems put people who are already at a disadvantage socially into a further health disadvantage (Braveman & Gruskin, 2003). Social determinants of health include economic and educational opportunities, quality and affordable housing, health promoting physical environments, family and community stability, cultural norms, food security, childhood living conditions, discrimination, transportation, access to health care services, and working conditions (OMHHP, 2008). Studies

have shown that an individual's socioeconomic status, including, education, wealth, job status, and income level has a greater impact on influencing health status than health behaviors and access to health care combined (OMHHP, 2008) (Lantz et al., 1998; Marmot & Rose, 1978). Furthermore, neighborhood level socioeconomic status affects health status independently from individual level socioeconomic status (Diez et al., 2001). The association between individual and neighborhood level of socioeconomic status and poor health extends across various health diseases and outcomes with varying causes and risk factors. As a result, social determinants of health has been also termed, fundamental cause of disease (Link & Phelan, 1995). In addition, health care also serves as a key social determinant of health as long as it is influenced by social policies. These influences include allocation of health care resources, financing of health care, and the quality of health care services (Braveman & Gruskin, 2003). Health determinants are the range of personal, social, economic, and environmental factors that determine the health status of individuals or populations. They are embedded in our social and physical environments. Social determinants of health are shaped by the distribution of money, power, and sources at global, national and local levels, which are themselves influenced by policy choices (Equity, 2009) (Organization, 2010).

Social and environmental factors are associated with health disparities across communities, lower-income communities and communities of color are “disproportionately burdened” by a higher incidence of certain diseases and conditions including heart disease, high blood pressure, and infant mortality (Miller, Simon, & Maleque, 2009). Researchers, in a study of health disparities among racial and ethnic groups, estimated that neighborhood poverty accounted for half of the excess risks observed among blacks and Latinos (compared with non-

Hispanic whites) for childhood lead poisoning, gonorrhea, tuberculosis, HIV/AIDS mortality and homicide (Krieger N et al) (Miller et al., 2009). Education and income affect health as they influence how an individual is treated in society, job availability, job security, resources needed to be healthy, environments in which people live, their ability to make and carry out healthy decisions, their exposure to other social determinants of health, and their levels of stress and coping strategies. Individuals and families living in poverty often need to prioritize basic survival such as paying rent and utilities and having sufficient food to eat over engaging in healthy behaviors. They are also more likely to face toxic levels of stress (referred to as allostatic load), which causes over activation of the body's stress response system (MacArthur Foundation, 2007; McEwen, 2006). This over activation of the body's stress response system may result in: psychological effects such as anxiety, depression, and a feeling of helplessness; heightened activity of the fight or flight response, which increases the risk of hypertension and heart disease; increased levels of the stress hormone cortisol which may increase the risk of obesity, diabetes, and depression; increased levels of hormones that alter the body's immune function and increase the risk of infection. Often as a result, individuals cope with high levels of stress through behaviors such as eating, drinking alcohol, smoking cigarettes, and using illegal drugs. Ultimately, the effects of toxic stress may escalate over a period of time and produce negative health consequences throughout an individual's entire life and across generations (MacArthur Foundation, 2007; Lu and Halfon, 2003).

### Social Advantages and Disadvantages

When comparing more or less advantaged social groups one must consider those things which place them at different levels in social hierarchy. Such examples of more or less

advantaged social groups include socioeconomic groups (defined by a measure of income, economic assets, occupational class, and/or educational level), and racial/ethnic groups (Braveman & Gruskin, 2003). Health disparities are also associated with social advantage and disadvantages, where the evidence is significant, frequent, and persistent and not just occasional or random (Starfield, 2001).

#### Health Inequity vs. Health Disparities

Health inequity is not just a health disparity or health inequality (Braveman & Gruskin, 2003). Health inequities are disparities in health or health care that are systematic and avoidable and considered unfair (OMHHP, 2008; Plough, 2006; Troutman, 2006). The concept of health equity appears when a health disparity or inequality is unfair and unjust (Braveman & Gruskin, 2003). Within health equity lies the concept that focuses attention on the distribution of resources and other processes which drive a very specific type of health inequality (a systematic inequality in health or in its social determinants) between more and less advantaged social groups (Braveman & Gruskin, 2003).

Health disparities, on the other hand, are the differences in the state of health between different groups. Health disparities exist when different groups experience different results from the same health issues (Droese et al., 2008). Not all health disparities are unfair (Anand, 2002). Examples of health disparities that are not necessarily unjust are explained by researchers Braveman and Gruskin (2003). It is expected for younger adults to be healthier than the elderly, for female infants to have a lower birth weight than a male infant, and for men to have prostate problems, however, it would be hard to argue that these are unfair or unjust. However, differences in nutritional status or immunization levels between boys and girls, or racial/ethnic



differences in the likelihood of receiving treatment for a heart attack, would be a grave concern from an equity perspective (Braveman & Gruskin, 2003). Health disparities can be measured by examining access to prevention, screening and treatment services, new cases of diseases, the amount of people with a disease, death occurring from a disease, and increased burden caused by a disease (Droese et al., 2008). When social determinants of health, including race, income, education, and other characteristics of the place where a person lives increases and influences the gaps, this leads to health inequity (Droese et al., 2008).

### The Ethical Principle

Health equity can be considered as an ethical principle, closely related to human rights principles (Braveman & Gruskin, 2003). The health levels of the most privileged groups in a given society at least reflect levels that clearly are biologically attainable, and minimum standards for what should be possible for everyone in that society within a foreseeable future. (Braveman & Gruskin, 2003). Equal opportunity to be healthy refers to the attainment by all people of the highest possible level of physical and mental wellbeing that biological limitations permit, noting that the consequences of many biological limitations are amendable to modification. The right to health cannot be separated from other rights, including rights to a decent standard of living and education as well as to freedom from discrimination and freedom to participate fully in one's society (Braveman & Gruskin, 2003).

### Health Inequity in the United States

Health inequities cost the United States more than \$1 trillion a year ("Robert Wood Johnson Foundation Commission for a Healthier America," 2009). The United States faces an

increasing level of inequity in the health status and mortality rates of its disadvantaged populations and in many communities of color (D. o. H. Equity, 2009). In general, in the United States, African Americans experience approximately 83,000 excess deaths (Satcher et al., 2005). In addition, less educated adults experience 195,000 excess deaths in comparison to college educated adults (Woolf, Johnson, Phillips, & Philipsen, 2007). Despite spending more on health care than any other nation, the United States ranks below many countries on key health indicators like infant mortality and life expectancy (Miller et al., 2009). While both infant mortality and life expectancy have improved over the last quarter-century, U.S. rankings have fallen relative to other nations: infant mortality slipped from 18<sup>th</sup> in the 1980 to 25<sup>th</sup> in 2002, and the ranking on life expectancy fell from 14<sup>th</sup> in 1980 to 23<sup>rd</sup> in 2004 ( OECD Health Data 2008).

According to a report by the United States Department of Health and Human Services on health disparities and the need for health care reform, The United States spends more than any other nation in the world on health care. In 2007, the average cost of health care was \$2.2 trillion (HHS & Office of the Actuary, 2009). Furthermore, while there are consistent increases in spending, disparities among demographic groups persist. Low-income Americans and racial and ethnic minorities experience disproportionately higher rates of disease, fewer treatment options, and reduced access to care. With unemployment on the rise, the disparities already apparent among these groups will continue to increase ( HHS, 2009).

In the United States, health varies dramatically across states and localities, and among social and economic groups. Health status among children varies by family income and education and by racial and ethnic group. Children in the least-advantage groups typically experience the worst health, but even children in middle-class families are less healthy than those

with greater advantages. Impressive gains have been made in recent decades in improving overall life expectancy and reducing overall rates of several chronic diseases and the factors that cause them. However, socioeconomic and racial and ethnic inequalities generally have not narrowed. Studies have shown widening socioeconomic gaps in health and health-related behaviors, such as smoking, and widening racial/ethnic gaps in maternal mortality. Health disparities among Americans who differ by social or economic status are keeping America from being as healthy as it should be. Closing the gaps not only will improve the quality of life nationwide but also promises to rein in escalating medical costs (Miller et al., 2009).

Chronic Diseases. Racial and ethnic minorities have high rates of debilitating disease such as obesity, cancer, diabetes, and AIDS. Disparities exist in the African American community, where 48% of adults suffer from a chronic disease compared to 39% of the general population (Halle, Lewis, & Seshamani, 2009; Mead et al., 2008). Obesity is often a cause of chronic disease. Seven out of ten African Americans ages 18 to 64 are obese or overweight, and African Americans are 15% more likely to suffer from obesity than Whites (Halle et al., 2009; Mead et al., 2008). African Americans die from cancer more than any other racial or ethnic group (*Cancer Facts and Figures 2008*, 2008; Halle et al., 2009). African American men are 50% more likely than White men to have prostate cancer. African American men are also more likely than any other racial group to suffer from colorectal cancer (Halle et al., 2009; Mead et al., 2008). Both Hispanic and Vietnamese women have disproportionate rates of cervical cancer, contracted at twice the rate of White women (Halle et al., 2009; McCracken et al., 2007; Mead et al., 2008). Fifteen percent of African Americans, 14% of Hispanics, and 18% of American Indians suffer from adult onset diabetes. American Indians have a diabetes rate more than twice

that of the White population, which develops the disease at a rate of only 8% (Halle et al., 2009; Mead et al., 2008). HIV exemplifies the most extreme disparity in chronic disease. (Halle et al., 2009). African Americans contract new HIV infections at seven times the rate of Whites, and Hispanics contract new HIV infections at two and a half times the rate of Whites (*HIV/AIDS Surveillance Report*, 2007).

**Health Insurance.** Access to quality care is important to overall health and wellness, and health insurance plays a significant role (Halle et al., 2009). Within the United States, disparities exist in rates of insurance and access to health care amongst ethnic minorities and low-income populations (Halle et al., 2009; Mead et al., 2008). Greater than one in three of Hispanics and American Indians, and close to one in every five African Americans are uninsured while one in eight Whites lacks health insurance (Halle et al., 2009; Mead et al., 2008). Of the nearly 46 million uninsured people in the United States, half of them are poor, and 4 out of every 10 low-income Americans do not have health insurance. Nearly one-third of uninsured individuals have a chronic disease. Uninsured individuals are also six times less likely to receive care for a health problem than those who are insured (*Medicaid and the Uninsured*, 2009). On the other hand, 94% of upper-income Americans have health insurance ( *National Healthcare Disparities Report*, 2008).

**Routine Care and Prevention.** Disparities in health are also apparent in the diversity in routine care and prevention among demographic groups. Having a primary care provider and a facility where a person can receive regular care substantially improve health outcomes (Halle et al., 2009). Hispanics, however, are only half as likely to have a usual source of care as compared to Whites. Furthermore, half of Hispanics and greater than a quarter of African Americans do

not have a regular doctor, compared with one fifth of Whites (Halle et al., 2009). In comparison to those with higher incomes, Americans living with low-income are three times less likely to have a usual source of care, and almost half of low-income Hispanics lack a usual source of care (Halle et al., 2009).

“Preventative care is paramount to stopping the root causes of disease as well as detecting diseases in their early stages when treatment is most effective” ( *National Healthcare Disparities Report*, 2008) In obesity prevention, Latinos are one-third less likely to be counseled on obesity than Whites (Halle et al., 2009). In prevention of AIDS, proper maintenance of HIV slows the virus from progressing to AIDS. Therefore, high rates of AIDS are an indicator of lack of access to needed care for HIV (Halle et al., 2009). African Americans are diagnosed with AIDS at a rate nine times that of Whites, and Hispanics are diagnosed with the AIDS virus at a rate three times the of Whites (*HIV/AIDS Surveillance Report*, 2007). While 57% of whites in the United States received a colorectal cancer screening, only 37% of Hispanics and 49% of African Americans received this screening type in 2007(Halle et al., 2009; Mead et al., 2008; *National Healthcare Disparities Report*, 2008). This disparity in cancer screening is believed to have contributed to colorectal cancer diagnoses for African Americans at more advanced stages, and a higher mortality rate of colorectal cancer in African Americans than any other race (Halle et al., 2009; Mead et al., 2008). Vietnamese women are half as likely to have had a Pap smear test in the past three years in comparison to White women. Sub sequentially, they have the highest rate of cervical cancer which is twice that of Whites. Furthermore, they are twice as likely to die from cervical cancer once the cancer develops (Halle et al., 2009; McCracken et al., 2007). Low-income women are 26% less likely than women in the highest income bracket to receive a mammogram, a “simple screening” that is vital to the early detection of breast cancer (Halle et

al., 2009). African American women suffer from breast cancer at a lower rate than White women, however, they die from the disease more often (Mead et al., 2008). In order to prevent the progression of diabetes, the disease requires constant management which includes hemoglobin testing, eye and foot examinations, influenza vaccinations, and lipid management. Less than one-third of people living within the poverty line receive these diabetes preventive measures, while more than half of people with high incomes receive proper care. Late term consequences such as kidney disease and foot amputations are much more likely among Hispanics and African Americans and occurs when diabetes is not managed properly (Halle et al., 2009; *National Healthcare Disparities Report*, 2008).

Environment, Communities, and Neighborhoods. The physical characteristics of neighborhoods affect health (Miller et al., 2009). Health can be impacted negatively by poor quality of air or water or living near facilities that produce or store hazardous substances (Miller et al., 2009). Lack of available nutritious foods and safe places to exercise, combined with concentrated exposure and fast-food outlets, appear to correlate with higher rates of obesity (Hill & Peters, 1998; Miller et al., 2009; Reidpath, Burns, Garrard, Mahoney, & Townsend, 2002). As one example, proximity to supermarkets, which usually sell fresh produce, has been linked with less obesity, while on the other hand, proximity to small convenience stores has been linked with increased obesity and smoking (Chuang, Cubbin, Ahn, & Winkleby, 2005 ; Miller et al., 2009; Morland, Roux, & Wing, 2006). Activity amongst individuals are more commonly experienced when they live in neighborhoods with better resources for exercises, such as parks, and walking or jogging trails; with less litter, vandalism, and graffiti; and with streets that are pedestrian-friendly (Giles-Corti & Donovan, 2002; Heinrich et al., 2007; Miller et al., 2009; "Robert Wood

Johnson Foundation Commission for a Healthier America," 2009). Nearly one fifth of all Americans, approximately 52 million people, live in poor neighborhoods and communities which lack the basic necessities to cultivate healthy living (Bishaw, 2005; Miller et al., 2009). Racial minorities or ethnic groups are more likely to live in such poor neighborhoods; approximately half of all blacks live in poor neighborhoods, compared with only one in 10 whites (Bishaw, 2005) (Miller et al., 2009).

Healthy homes and communities are out of reach for many families. Substandard housing is much more of a risk for some families than others; housing varies dramatically by social and economic circumstances. Families with fewer financial resources are most likely to experience unhealthy and unsafe housing conditions and typically are least able to remedy them, contributing to disparities in health across economic groups (Miller et al., 2009).

### Health Inequity in Virginia

The 2008 Virginia State Department of Health Office of Minority Health and Public Health Policy Health Equity Report is a great depiction of the health inequity that exists within Virginia. According to the report, in Virginia, morbidity and mortality amongst various health conditions differ significantly amongst racial, socioeconomic, and ethnic individuals and communities. Also, in the report, it is quite evident that Virginia holds a health gradient that follows the socioeconomic gradient where, Virginians of high socioeconomic status, on average, live longer and healthier lives than Virginians of middle socioeconomic status, who live longer and healthier lives than Virginians of lower socioeconomic status (*OMHHP, 2008*). The following data and statistics are adapted from the 2008 Virginia Department of Health Office of Minority Health and Public Health Policy 2008 Health Equity Report.

Immigration. Hispanics and Asians are the fastest growing population in Virginia and comprise 6.3% and 4.3% of Virginia's population respectively. Virginia also ranks amongst the top 15 states for refugee settlement, due to the large numbers of foreign immigrants to Virginia. According to the 2000 Census, 11% of Virginia residents over the age of 5 have a primary language other than English. Of this population 41% speak English "less than well", and 21% live in linguistically isolated households (households where no member over 14 years of age speaks "only English" or speaks English "very well") Also according to the 2000 Census, the number of students receiving English as a second language (ESL) through Virginia public schools increased by 82% (from 36, 799 to 66, 790) (OMHHP, 2008).

Socioeconomic Status. Nearly 15% of Virginia's population over 25 have not earned a high school diploma or equivalent with African Americans holding a higher percentage at this level of education or less. In 2005, 10% of the population fell below the federal poverty level, placing them at a multitude of health problems. That year, 13% of children amongst all racial and ethnic groups lived in poverty. As a whole, the African American total population and African American children were 2½ and 3 times more likely to live in poverty than the White population respectively. African American children account for 49% of all children living in poverty. In Virginia, as the concentration of poverty within the census tract increases, the proportion of Asians, Hispanics, and Whites living in those census tract decreases. However, African Americans are more likely to live in those census tracts with a high concentration of poverty. Twenty-five percent of African Americans live in high poverty census tracts in comparison to 6% or less of all other racial and ethnic groups. In addition, rural population are more likely to



live in high poverty census tracts than urban populations (14.6% vs. 8.7%) and they are three times more likely to live in moderately high poverty census tracts as well (OMHHP, 2008).

“Double Jeopardy” is defined as living in a family which falls below the federal poverty line and living in a high poverty census tract. In the Commonwealth, 3.8% of all children live in “Double Jeopardy”. This includes 0.8% of Asian children, 1.1% of White children, 2.0% of Hispanic children, 2.2% of other race children, and 12.7% of African American children. Hispanic children are roughly twice as likely to experience double jeopardy as white and Asian children, and African American children are 12 times more likely to experience double jeopardy than White and Asian children (OMHHP, 2008).

Birth Data. In 2006, there were 106,474 resident births. Whites accounted for 67% of all births (71,338), blacks accounted for about 22% (23,171) of these births, Hispanics accounted for more than 13% (14,351) of these births, Asian/Pacific Islanders made up about 7% (7,112) of these births, and only 0.15% (1400) of births was Native American. Hispanic/Latino women had the highest birth rate at 29.9 per 1,000 population, Asian/Pacific Islander followed at 18.2, blacks had a birth rate at 14.9, whites had a birth rate at 12.9, and the Native American birth rate was lowest at 4.9. Greater than 63% (14,896) of African American babies, over 50% (7,241) of Hispanic babies, and almost 40% of Native American births were born to unwed mothers. In contrast, fewer babies, 26% (19,159) of White births and 8% (572) of Asian/Pacific Islander births were born to unmarried mothers. More than half (52.9%) of Virginia’s mothers had completed at least a year of college education in 2006. The highest percentage (77.6%) of births to college educated women were found in Asian/Pacific Islanders. Half of Native American mothers, 50%, had some college education followed by 40.1% of Black mothers who had a year

or more of college education. The lowest percentage of college-educated mothers at 22.1% was found in Hispanic/Latinos. Furthermore, greater than 20% of Hispanic/Latino mothers had six years of education or less (OMHHP, 2008) .

Babies born of low weight are more likely to experience serious medical complications, delays in development or even die before the first year of life . The percent of low weight births was lowest among Hispanic/Latino (6.0%, 855 births) followed by White and Asian/Pacific Islander with 7.0%, 5,125 births and 7.6%, 542 low weight births respectively. Black mothers had nearly double the percent of low birth weight babies as compared to Whites at 12.9% (2, 993) (OMHHP, 2008). Women with less education carry a higher risk of delivering a low weight infant, and those with less than a high school equivalent degree are 1.4 times more likely to have a low weight birth in comparison to those women who have an education beyond a high school equivalent degree (OMHHP, 2008). However, at every educational level, African American women are 1.5 to 2 times likely to deliver a low weight infant than white women. Furthermore, African American women with greater than 12 years of education are more likely to give birth to low weight infant than women of any other race/ethnicity with less than 12 years of education (OMHHP, 2008).

**Infant Mortality Rate.** The infant mortality rate is considered an indicator of the overall well-being of a community as it reflects the health of the mother prior and during pregnancy, access to quality care across the lifespan, behaviors, family dynamics, social support, social capital, family and community socioeconomic characteristics, and other factors (Lu & Halfon, 2003; OMHHP, 2008). The leading causes of death to infants in Virginia are due to conditions beginning in the prenatal period, congenital anomalies, and sudden infant death syndrome. In

2006, the infant mortality rate for Blacks was twice that the rate of whites. The infant mortality rates were 13.8 per 100 live births and 5.5 per 1,000 live births for Blacks and Whites respectively. In 2006, Asian/Pacific Islander had an infant mortality rate of 4.2 per 1,000 live births and Hispanics had an infant mortality rate of 4.1 per 1,000 live births (OMHPHP, 2008). Women with less than 12 years of education are 2.1 times more likely to experience an infant death than women with greater than 12 years of education. However, similar to the trends of low birth weight, African American women at all educational levels are more likely (1.7 to 2.3 times) to experience an infant death. Furthermore, African American women with greater than 12 years of education have higher infant mortality rates than other women with less than 12 years of education. Across all educational levels, Hispanic women and women of other races had the lowest rate of infant mortality (OMHHP, 2008).

Women belonging to all races and ethnicities are at an increased risk of infant death as the poverty rate in their community increases. Women living in census tracts with the highest poverty level are 2.8 times more likely to experience an infant death than women in census tracts with the lowest levels of poverty. In addition, Black women experience infant mortality rates that are at least 1.5 times higher than other women at all census tract poverty levels (OMHHP, 2008). During the period from 1996-2005, infant mortality rates were approximately 8% higher in rural census tracts as compared to urban census tracts. The infant mortality rate was 22% higher in rural census tracts among White women, and among Black women, the infant mortality rate in rural census tracts was about 5% lower as compared to urban areas (OMHHP, 2008).

Teenage Pregnancy. Teenage pregnancy rates for 15-17 year old females were highest among Hispanic/Latino (47.5/1,000 females 15-17) and Black females (45.0). In comparison,

teenage pregnancy rates among White and Asian/Pacific Islanders females were (14.4) and (5.6) respectively (OMHHP, 2008). The highest rates of teenage pregnancy for 18-19 years olds were among Hispanic/Latino and Black women (183.8) and (137.9) respectively. The lowest rates were among Whites and Asian/Pacific Islander women (61.1) and (32.3) respectively. While five year trends for teen pregnancy have show a overall decrease in teen pregnancy that has evened over the last several years, there has been an overall upward trend in teen pregnancies among Hispanics (OMHHP, 2008).

General Mortality. When viewing the twelve leading causes of death, with the exception of suicide, Virginians with less than 12 years of education have the highest rate of mortality, followed by those with 12 years of education. Virginians with the lowest rates of mortality are those having greater than 12 years of education (OMHHP, 2008). The standardized mortality ratio by census tract (CT) poverty summarizes the mortality for all causes relative to the mortality that would be expected, based on the demographics of the population living within each census tract poverty level. During 2001-2005, as census tract poverty increases, standardized mortality increased. In the lowest poverty CT in Virginia, mortality rates were 4% lower than expected. In the next three categories of increasing CT poverty, mortality rates were 5%, 7%, and 24% higher than expected. This is consistent with nationwide data demonstrating that the gradient in health status is not just for poor and non-poor. At each decreasing step of Socioeconomic status [in this case, as CT poverty increases] health status worsens (OMHHP, 2008). In viewing the three leading causes of death (heart disease, cancer, and cerebrovascular disease), African Americans had mortality rates from 23% to 15% higher than whites. Heart

disease, cancer, and cerebrovascular causes accounted for approximately 70% of deaths (OMHHP, 2008).

The Latino Paradox. The “Latino Paradox” is the unexpected finding of lower mortality rates among Latinos, despite social marginalization and greater rates of poverty than Whites (OMHHP, 2008). This phenomenon is suggested to be associated with the stronger social networks among Latino immigrants. Their health outcomes worsen, however, once Latino and other immigrants gain American culture, norms, and behaviors and lose their traditional social networks and hopefulness they once possessed while entering into the United States, such as through experiencing racism, and poverty rates that are higher than the average population (especially among Latinos) (OMHHP, 2008) (Koya & Edge, 2007).

#### Addressing the Social Determinants of Health and Health Equity

Equalizing opportunities to be healthy requires addressing the most important social and economic determinants of health not only in health care, but also in living conditions, and policies that affect any of these factors (Braveman & Gruskin, 2003). People are beginning to understand that only addressing individual factors has not improved health for all groups over time (Droese et al., 2008). Individuals, communities, health care, business and unions, philanthropies, and local, state and the federal government must work together. Change must go beyond the health care system to include policies that influence economic opportunity, early childhood development, schools, housing, the workplace, community design and nutrition (Miller et al., 2009). Looking at and addressing social, structural and environmental factors may have a broader and more lasting impact on health (Droese et al., 2008). For example, just focusing good eating and exercise habits does not address issues like having health insurance or

going to the doctor. Similarly, going to the doctor does not eliminate the environmental impacts of living in conditions that are likely to worsen a chronic condition like asthma (Droese et al., 2008). In the United States, the general opinion is that most influential factors are more individualistic, which leads to less government intervention and support. In countries where social and environmental factors are considered more important, there is often more government intervention. All of these factors can impact health (Droese et al., 2008). Due to the strong influence by marginalization on the social determinants of health by race, ethnicity, and socioeconomic status, in order to eliminate inequities and to create health equity, it is essential that all population groups have fair access to resources and opportunities to be healthy (Hofrichter, 2006; OMHHP, 2008).

Traditional health care and individual behavior change strategies must be expanded to include an explicit focus on the social determinants of health in order to eliminate health inequities in Virginia (OMHHP, 2008). In “Unequal Health Across the Commonwealth: A Snapshot Virginia Health Equity Report 2008”, Dr. Michael Royster, provides a list of recommendations to promote health equity by addressing the social determinants of health (OMHHP, 2008 pg. 43). These recommendations, based on evidenced-based public policy recommendations found in the literatures of such organizations as the World Health Organization and the MacArthur Foundation are to:

- 1) Conduct health impact assessments (HIA) for all public policies likely to have direct or indirect influence on health. Health impact assessment is an evaluation of the potential impact of public policy options on health and health inequities. Examples of health impact assessments

are public policy sectors that impact health include land use planning, economic policy, education policy, community redevelopment, and transportation.

2) Monitor health inequities and SDOH and evaluate the effectiveness of measures to reduce them.

3) Focus on policies to improve health and reduce inequities among women of childbearing age, pregnant women, and children.

4) Combine federal, state, and local policies that determine the distribution of opportunities to be healthy.

5) Advocate for and implement policies that improve SES, such as equalizing educational quality in impoverished communities; establishing a living wage or minimum wage tied to inflation; reducing child poverty; undoing policies and practices that enforce residential racial segregation.

6) Advocate for and implement policies that buffer the effects of low SES, such as creating safe places to be physically active and increasing access to healthy foods through zoning, partnerships, tax incentives, etc.; reducing workplace hazards and expanding health promoting policies; increasing availability of quality and affordable housing.

In a related article on addressing the social determinants of health, Dr. Jones uses the “Cliff Analogy” to explain that moving the population away from a cliff to keep them from falling off the cliff would be similar to addressing the social determinants of health. In addition to the importance of addressing the social determinants of health, however, Jones explains that equally important would be to address the social determinants of equity (SDOE). Jones depicts a cliff that is three-dimensional where some areas of the cliff have a population that is closer to the edge than others. So in terms of the “Cliff Analogy”, addressing the Social Determinants of

Equity would entail asking the questions or looking for solutions as to why is the cliff three-dimensional; why are some people fatter than others. This would represent an interest in the unequal distribution of resources and policies. According to Dr. Jones, the only way that true effectiveness and solutions can be achieved will be through addressing the social determinant of health and social determinants of equity. Addressing only the social determinants of health may result in further disparities as help may be provided to some and not others (Jones, Jones, Perry, Barclay, & Jones, 2009).

#### Tackling Health Inequity and the “*Health Equity Campaign*”

Public policy priorities to create equal opportunities to be healthy include those that focus on reducing the burden of poverty and related social determinants of health and reducing the negative impact of living in disadvantaged communities. Effectively addressing such issues requires partnerships with policy makers outside of the traditional health realm (e.g., economic development, housing and community development, education, social services). In addition, it is important for these policy makers to recognize the significant impact of their work on health and implement policies and programs that promote health and health equity (OMHHP, 2008).

Since equity in health means equal opportunity to be healthy for all population groups. Equity in health therefore implies that resources are distributed and processes are designed in ways most likely to move toward equalizing the health outcomes of disadvantaged social groups with the outcomes of disadvantaged counterparts. This refers to the distribution and design not only of health care resources and programs, but of all resources, policies, and programs that play an important part in shaping health, many of which are outside the immediate control of the health sector (Braveman & Gruskin, 2003).



Because the concept of health equity is one that is multifaceted in many different aspects of society, the *Health Equity Campaign* serves as an important tool to educate others on defining and becoming aware of health equity while at the same time becoming able to appropriately measure health equity in order to seek out proper interventions. The *Health Equity Campaign* is directed by the Virginia Department of Health Office of Minority Health and Health Policy Division of Health Equity. The Division of Health Equity works with stakeholders to identify approaches to eliminate health inequities through a focus on social determinants of health and social justice, in addition to more traditional health promotion, as key strategies to eliminate health inequities that exist by socioeconomic status, race/ethnicity, geography, gender, immigrant status and other social classifications (D. o. H. Equity, 2009) .

The *Health Equity Campaign* originated as a partnership between The National Association of County and City Health Officials (NACCHO) and California Newsreel on its four-hour documentary series for PBS titled, "Unnatural Causes: Is Inequality Making Us Sick?" Through this campaign, NACCHO has helped many local health departments convene town hall meetings and other events to screen the film and discuss actions to tackle health inequity. Participants include community representatives, agency heads, elected public officials and others (NACCHO, 2009).

The *Health Equity Campaign* is a part of the NACCHO Health Equity and Social Justice Initiative. NACCHO's Health Equity and Social Justice Initiative explore why certain populations bear a disproportionate burden of disease and mortality and what health departments can do to better address the causes of these inequities. The goal of NACCHO's Health Equity and Social Justice initiatives is to advance the capacity of local health departments to tackle the root

causes of health inequities through public health practice and their organizational structure (NACCHO, 2009).

### Unnatural Causes: Is Inequality Making Us Sick?

“Unnatural Causes: Is Inequality Making Us Sick?”, is a pioneering 4-hour PBS documentary series with an ambitious outreach and public health impact campaign to help reframe the nation’s debate over health and what we as a society can—and should—do to reduce our socio-economic and racial health disparities. The centerpiece of the series is an hour-long opening episode that sets up the overarching themes of the series: health and longevity are correlated with socioeconomic status, and people of color face an additional burden; and solutions lie not in more pills or better genes, but in better social policies (OMHPHP, 2009).

The *Unnatural Causes* documentary is divided into the seven episodes. The seven programs are divided as follows: 1) “*Sick of It?*”- which asks the question why do some of us get sicker and die sooner?, 2) “*Place Matters*” - which discusses the fact that a street address can be a powerful predictor of health, 3) “*Becoming American*”-a depiction that on average poor immigrants of color arrive into the United States with better health than the average American, 4) “*When the Bough Breaks*”- demonstrates that African-American with professional degrees have the same rate of having a baby born prematurely and with low birth weight as white high school dropouts, 5) “*Bad Sugar*”- discusses that Native Americans were the first to suffer the effects of the growing diabetes epidemic in The United States, 6) “*Not Just a Paycheck*”- explains that unemployment and job insecurity has a negative impact on health , and 7) “*No Man is an*

*Island*”- proves that Pacific Islanders even Native Hawaiians have poor health outcomes (Newsreel, 2008; excerpt from Division of Health Equity webpage OMHPHP, 2009).

### Related Interventions Promoting Health Equity

There are a number of successful interventions already in place that tackle the issue of health inequity and were created to promote health equity. The New Framework is a concept introduced to the Virginia Department of Health Office of Minority Health and Public Health Policy Division to promote health equity. It demands a focus on behavior change and access to quality health care be informed by a commitment to advance health equity and social justice (Royster, 2009b). This is described as within the healthcare setting: Assuring that all patients have access to and receive culturally and linguistically appropriate and high quality healthcare; making office hours conducive to the schedules of patients who do not have paid leave and/or work non-traditional hours; linking disadvantaged patients to needed social and economic services and resources within their communities in order to improve compliance; participating in or leading community efforts to promote health equity; and advocating for improvements in the social determinants of health and for social justice. Within efforts to promote healthy behaviors commitment to health equity and social justice includes: Recognizing that behaviors are influenced by much more than knowledge of healthy practices; focusing on a multi-level approach to health promotion that involves evidence-based interventions targeting individual interpersonal, organizational, community and policy factors that influence health; using a community based participatory approach that involves disadvantaged communities as equal partners in identifying community problems and assets; researching issues that are community priorities; developing, implementing and evaluating interventions; and promoting social change;

and forming diverse partnerships across sectors that influence health (health care, faith communities, non-profits, education, housing, transportation, social services, economic development, planning, law enforcement, etc.) (Royster, 2009b).

This framework to promote health equity was first developed as it was incorporated into the Alameda County Health Department and the Bay Area Health Inequities Initiative in the San Francisco Bay Area (Michael O. Royster, ; OMHHP, 2008). This socio-ecologic framework for health identifies underlying social inequalities and the importance of targeting “upstream” social factors in addition to “downstream” factors, such as behaviors and access to care, which are strongly influenced by these upstream factors (Iton, 2008; OMHHP, 2008; Royster, 2009; Sallis & Owen, 1997)

#### Healthy People Initiative

Healthy People 2010 was created as a program sponsored by the federal government (Droese et al., 2008). The program is based on a set of goals to be achieved on a national level by the year 2010 (Droese et al., 2008). States, communities, professional organizations and others use the objectives as a starting point for programs to improve health (Droese et al., 2008). The second goal of Healthy People 2010 was to eliminate health disparities among different segments of the population (Droese et al., 2008). Since the development of the healthy people initiative, more recent programs including Healthy People 2020 have grown past the issue of health disparities to address health equity and the social determines of health in health interventions as a means to obtain desired health outcomes. There is currently in place a structural framework for Health People 2020. The recommended overarching goals for Healthy

People 2020 continue the tradition of earlier Healthy People initiatives of advocating for improvements in the health of every person in our country (HHS, 2008). The goals of Healthy People 2020 address the environmental factors that contribute to our collective health and illness by placing particular emphasis on the determinants of health. The overarching goals for Health People 2020 include; to achieve health equity, eliminate disparities, and improve the health of all groups, and to create social and physical environments that promote good health for all (HHS, 2008). The United States Department of Health and Human Services intends to develop objectives for the social determinants and methods to ensure their integration across all Healthy People 2020 objectives (HHS, 2008).

### Summary

In summary, health equity is an ethical value, inherently normative, grounded in the ethical principle of distributive justice and constant with human rights principles (Braveman & Gruskin, 2003). To the contrary, health inequities are differences in health status and mortality rates across population groups that are systemic, avoidable, unfair, and unjust (D. o. H. Equity, 2009). A key factor in providing successful interventions to promoting health equity lies in the ability to understand the concept of health equity, and henceforth give an accurate measure of the health inequities and social determinants of health which are evident in a particular area. In the United States and within the commonwealth of Virginia, there are vast amounts of health inequities that are apparent and exist in every aspect of health. Through the use of the “Unnatural Causes...Is Inequality Making Us Sick?” documentary, the *Health Equity Campaign* is an essential tool for making communities and organizations aware of these existing health inequities and for providing much needed solutions to the immense problem of health inequity.

## Chapter 3

### Methodology

#### Research Design

This research was a collaborative effort between the principal investigator and the Virginia Department of Health Office of Minority Health and Public Health Policy Division of Health Equity to evaluate the *Health Equity Campaign* based on surveys and interviews.

The target population included all adult individuals belonging to organizations that have received presentations coinciding with the “Unnatural Causes...Is Inequality Making Us Sick?” documentary as part of the Virginia Department of Health OMHPHP *Health Equity Campaign*. There was no exclusion as to gender, race, ethnicity, occupation, or socioeconomic status. There was an approximated fifty eligible participants total, with an approximated thirteen of these serving as possible interview participants (the organization or group leaders).

A letter formally inviting individuals to participate in this study was emailed to organization/group leaders (Appendix B). Organization/group leaders served as the source of contact to recruit and inform survey participants about the study and survey. In addition in the email, organization/groups leaders were also asked to participate in an interview. Informed consent was provided regarding the purpose of this research. Before entering the online survey, the participants electronically agreed to the informed consent page which had to be agreed upon through selecting the appropriate box before accessing the survey (Appendix C). Immediately following the informed consent, participants completed surveys and/or interviews.

## Validity/Reliability

The present study has face validity as survey and interview questions were directly related to this research. Survey and interview questions were based on the research question and the three levels of the Kirkpatrick's evaluation model. This study was reliable in that survey and interview responses were redundant.

## Intervention

The Virginia Department of Health Office of Minority Health and Public Health Policy began implementing the *Health Equity Campaign* in November of 2007. This campaign is an on going program by the department. As part of the campaign, numerous organizations within Virginia met within their respective organizations to view the documentary, "Unnatural Causes,... Is Inequality Making Us Sick?". Presentations of the documentary were led by various OMHPHP staff including Office Director, Division Director, Health Equity Specialists, Community Outreach Specialist, and members of the Minority Health Advisory Committee. All presentation leaders received a half day train the trainer session.

Each presentation lasted approximately one to three hours and consisted of a five minute introduction of the documentary followed by viewing various episodes and clips. "*When the Bough Breaks*" has been used to mainly target audiences who were addressing infant mortality. "*Place Matters*" was used very often as this segment covered a wide spectrum of social determinants of health. The other segments of the documentary were also used. After the initial meeting and presentation, some organizations chose to follow up and view additional segments on their own.

## Instrument

A likert scale survey was created and utilized with questions to evaluate the *Health Equity Campaign* in regards to the research objectives. The survey questions were developed by the research investigator, the director of the Virginia Department of Health Office of Minority Health and Public Health Policy, and the office director of the Division of Health equity. The survey questions were developed from three key questions that target the three levels of the Kirkpatrick's evaluation model. These three levels determine: 1) Participants' reactions as to whether or not they were satisfied with the presentations or felt that they were relevant 2) The extent to which participants have improved or increased their knowledge as a result of the presentations 3) Participants' behavior as a result of their new knowledge, attitudes, and beliefs within their current environment.

The three key questions used were: 1) What did participants think about the *Health Equity Campaign* presentations? 2) To what extent did the *Health Equity Campaign* meet its goal of getting participants to learn and become aware about health equity? 3) To what extent did the program meet its goal of getting participants and their organizations to advocate and take action towards health equity?

The fifteen likert responses used were: 1) *The presentation was well organized* 2) *The presentation was informative* 3) *The presentation was overall beneficial to me* 4) *The presentation was a good use of my time* 5) *The presentation enabled me to understand a broader definition of health and health equity* 6) *The presentation increased my understanding of the difference between health inequity, health inequality, and health disparities* 7) *The presentations increased my understanding of the meaning of the social determinants of health* 8) *The presentation*



*increased my awareness of health equity/inequity in the United States 9) The presentation increased my awareness of health equity/inequity in Virginia 10) The presentation increased my awareness of health equity/inequity in my neighborhood/community 11) As a result of the presentation, I now discuss health equity with others 12) As a result of the presentation, I am motivated to work to help solve the problems of health inequities 13) I believe that the presentation has given my organization/myself the tools to take action to address the problems of health inequities 14) As a result of the presentation, my organization/I have developed plans to take action in my neighborhood/organization/community to promote health equity 15) As a result of the presentation, my organization/ I am now taking action in my neighborhood/organization/community to promote health equity.*

Key question 1) What did participants think about the Health Equity Campaign presentations? correlated with the statements 1) *The presentation was well organized 2) The presentation was informative 3)The presentation was overall beneficial to me 4)The presentation was a good use of my time.* Key question 2) To what extent did the Health Equity Campaign meet its goal of getting participants to learn and become aware about health equity? correlated with the statements 5) *The presentation enabled me to understand a broader definition of health and health equity 6)The presentation increased my understanding of the difference between health inequity, health inequality, and health disparities 7) The presentations increased my understanding of the meaning of the social determinants of health 8) The presentation increased my awareness of health equity/inequity in the United States 9) The presentation increased my awareness of health equity/inequity in Virginia 10) The presentation increased my awareness of health equity/inequity in my neighborhood/community.* Key question 3) To what extent did the

program meet its goal of getting participants and their organizations to advocate and take action towards health equity? correlated with the statements 11) *As a result of the presentation, I now discuss health equity with others* 12) *As a result of the presentation, I am motivated to work to help solve the problems of health inequities* 13) *I believe that the presentation has given my organization/myself the tools to take action to address the problems of health inequities* 14) *As a result of the presentation, my organization/I have developed plans to take action in my neighborhood/organization/community to promote health equity* 15) *As a result of the presentation, my organization/ I am now taking action in my neighborhood/organization/community to promote health equity.*

Participants rated the *Likert* scale statements on the scale of 1 through 5. Participants rated the statements as: 1 (Strongly Disagree), 2 (Disagree), 3 (Neither Agree or Disagree), 4(Agree), or 5 (Strongly Agree). A rating of 1 indicated that the participant *Strongly Disagreed* to the above statement. A rating of 2 indicated that the participant *Disagreed* to the above statement. A rating of 3 indicated that the participant *Neither Agreed or Disagreed* to the above statement. A rating of 4 indicated that the participant *Agreed* to the statement. A rating of 5 indicated that the participant *Strongly Agreed* to the above statement. The survey questionnaire was completed online and took an approximated 15-30 min to complete (Appendix D).

*Survey Monkey* is one of the online surveying methods of choice used for the Virginia Department of Health Office of Minority Health and Public Health Policy Division of Health Equity. The web site is primarily used by the Division of Health Equity for various purposes such as follow- up quizzes, surveys, and polling.

The following eight interview questions were asked to each group/organization leader in the following order: 1) *Which episode of the “Unnatural Causes...Is Inequality Making Us Sick?” documentary have you viewed?;* 2) *How has the presentation influenced your organizational programming?;* 3) *What specific changes have you made?;* 4) *What are you currently doing or what are any plans that you may have to promote health equity in your organization, neighborhood, or community?;* 5) *When have you began or will begin?;* 6) *What were the strengths of the presentations?;* 7) *What were the weaknesses of the presentations?;* 8) *What other information would you add to the presentations to make it better?*

The research investigator served as the primary instrument to conduct the interviews with group/organization leader. Each interview time varied and was conducted either at the participant’s respective locations within the Virginia Department of Health, at their respective institutions, or via telephone.

#### Data Collection and Analyses

Data from the surveys were collected and compiled within the Virginia Department of Health OMHPHP Division of Health Equity utilizing the online database of responses. Interviews were tape recorded, transcribed, and analyzed by the research investigator.

Scores were used to measure the objectives. For example, a high score (4-5) in questions 1-4 indicates participants were satisfied with the campaign. A high score (4-5) in questions 5-10 suggest that the Health Equity campaign met its goal of getting participants to learn and become aware about health equity. A high score (4-5) in questions 11-15 suggests that the Health Equity campaign met its goal of getting participants and their organizations to advocate and take action

towards health equity. Descriptive statistics were used to obtain the mean score to each of the fifteen statements.

Eight organization/group leaders responded to an email inviting them to participate in an interview. Interview participants set up a time and date in which the interview would take place and whether the interview would take place via telephone or face-to-face based on their convenience and the scheduling and locations of other interviewed participants. One-half (four) of the interviews were conducted face-to-face at the participants organizations and another half (four) were conducted over the phone. Before beginning the survey, participants who received the face-to-face interview signed the informed consent. Those participants who were interviewed over the phone were emailed a copy of the informed consent form before the interview and verbally agreed to the informed consent immediately preceding the interview. The interviews were conducted and transcribed by the principal investigator. Interviews varied in length depending on the participant's experiences and uses with the documentary and presentations. The interviews ranged from twenty minutes to an hour and thirty minutes.

A qualitative analysis was used to analyze responses from the interviews to look for common themes and responses in relation to the research question and objectives. After all interviews were completed and transcribed, responses were entered into a category correlating with one of the eight interview questions that were asked. Responses from eight of the interview participants were entered in each of the eight categories and listed in chronological order to when the interview was conducted. The constant comparison method was used to analyze the interview responses. Phrases and quotes were coded and grouped in comparing and contrasting themes.

The results of the interview were used to develop a list of recommendations to further increase knowledge, awareness, and advocacy of health equity within Virginia.

#### Timeline

The establishment of contact information of possible participants took three months. The recruitment process, establishment of meeting times, interviews, and survey distribution and collection of responses took one month. Data analyses and interpretation of surveys and interviews were also completed in a duration of one month.

## Chapter 4

### Results

The purpose of the current study was to evaluate the impact of the Virginia Department of Health Office of Minority Health and Public Health Policy (OMHPHP) *Health Equity Campaign* on various individuals and organizations within Virginia. A list of possible contacts and prospective participants, who have been at one time during the course of the campaign, participants in the *Health Equity Campaign* was compiled by the Principal Investigator and members of the Virginia Department of Health Office of Minority Health and Public Health Policy Division of Health Equity. After compiling this list, prospective participants were chosen on the basis that the groups received a presentation within the time period from when the health equity campaign began in November of 2007 to November 2009. Contact was established through the research investigator. An email was sent out to thirteen group leaders inviting them to participate in the study. Out of the thirteen group leaders, eight of them responded and agreed to participate in the study. These eight group leaders represented their organization in the study through participating in the interview portion of the study. The eight group leaders were contacted via email to participate in an in depth interview and also asked to forward an online survey link to their respective staff members to complete the survey and to also complete the online survey themselves.

The eight participant groups consisted of the Eastern Virginia Medical School Division of Community Health and Research -Department of Pediatrics (Asthma Coalition), Norfolk State University Department of Political Science, The Fan Free Clinic, Virginia Commonwealth University Center for Health Disparities, Virginia Department of Health Henrico Health District,

Virginia Department of Health HIV Planning Committee, Virginia Department of Health Three Rivers Health District, and the Virginia Department of Health Virginia Heart Disease and Stroke Alliance. (Appendix E) There were approximately 30 survey participants. A total of 30 online surveys were attempted. A few surveys were not completed and only demographic and background information was entered. The following gives a detailed description of the survey and interview responses pertaining to the research question:

What impact has the *Health Equity Campaign* presentations had on enabling organizations and its members to incorporate a focus on health equity into their organizational policies, practices, and programs?

#### Survey Responses-Demographics

City/Town of Residence. In the survey questionnaire participants were first asked to list their City/ Town of Residence. There were 28 replies. The responses to this question were Chase City, Chesapeake, Chesterfield, Fredericksburg, Glen Allen, Gloucester, Hampton, Hanover, Henrico County, Howertons, Mechanicsville, Newport News, Portsmouth, Richmond, and Wise. Eleven participants listed Richmond as their City/Town of Residence. One participant noted that they do not reside and work in the same City/Town and listed both areas where they did reside and work.

Occupation. Participants were also asked to list their occupations. There were 28 responses. The general responses to this question without giving away specific identities were Case Manager, Community Organizer, Health Consultant, Health Director, Health Educator, Health Promotion Specialist, Nurse, Outreach Specialist, Program Coordinator, Researcher, and

Registered Nurse. Many of the responses listed were Health Educator and Registered Nurse. There were six participants who listed Health Educators as their occupation and also six participants who listed Registered Nurse as their occupation.

Age Group. Also as part of demographic information, participants listed in which age group category they belonged. There were 29 responses to this part of the survey. None of the participants selected the category groups 18-20 and 21-30. Many of the participants thirteen (44.8%) fell into the category 51-60. Following, eight (27.6%) participants selected 41-50, four (13.8%) selected 61-65, three (10.3%) selected 31-40, and one (3.4%) selected  $\geq 65$ .



Table 1

*Demographics*

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	Frequency
Chase City	1
Chesapeake	2
Chesterfield	1
Fredericksburg	1
Glen Allen	1
Gloucester	1
Hampton	1
Hanover	1
Henrico County	1
Howerstons	1
Mechanicsville	2
Newport News	1

Norfolk	1
Portsmouth	1
Richmond	11
Wise	1

#### Occupation

Community Organizer	1
Dental Health Educator	1
Development Director	1
Director	1
Disability Consultant	1
HDS	1
Health Educator	6
Health Promotion Specialist	1
HIV/Aids Case Manager	1
IDU Outreach Specialist	1
Lay Health Promoter & Community Health Program Coordinator	1

Nurse Research	1
Registered Nurse	6
STD Program Coordinator	1
Volunteer Coordinator	1

#### Age Group

18-20	0
21-30	0
31-40	3
41-50	8
51-60	13
61-65	4
≥ 65	1

#### Survey Responses-Background

Organization. As part of the survey , participants were asked to identify themselves in one of the 13 groups that were initially contacted or “other”. A total of 29 participants responded to this question. The participants listed themselves belonging the following groups; Virginia Heart Disease and Stroke Alliance 14 (50%), Virginia Department of Health, OMHPHP/UVA

Video Conference 2 (7.1%), Virginia Department of Health, Tobacco Control Conference 2 (7.1%), The Fan Free Clinic 3 (10.7%), Three Rivers Health District 3 (10.7%), Other 3 (10.7%) “CINH ANNUAL Meeting, CINCH (but also am a member of the VA Asthma Coalition), OMHPHP Conference.

Time of OMHPHP presentations. Participants were asked to select from which of the four categories listed ( *LESS THAN 1 MONTH AGO*, *Between 1 MONTH- 6 MONTHS AGO*, *Between 6 MONTHS-1 YEAR AGO*, or *GREATER THAN 1 YEAR AGO*) described the time in which they have participated in the presentation. One participant (3.6%) selected *LESS THAN 1 MONTH AGO*, 17 participants (60.7%) selected *Between 1 MONTH- 6 MONTHS AGO*. Five participants (17.9%) selected *Between 6 MONTHS- 1 YEAR AGO*, and five participants (17.9%) selected *GREATER THAN 1 YEAR AGO*.

Episodes Viewed. Participants were asked to select from the listed group of episodes in which they have viewed as part of the presentation. Participants were able to select all episodes that they have viewed or none. Nine participants (32.1%) viewed Episode 1- *In Sickness and in Wealth*. Six participants (21.4%) viewed Episode 2- *When the Bough Breaks*. Four participants (14.3%) viewed Episode 3- *Becoming American*. Five participants (17.9%) viewed Episode 4- *Bad Sugar*. Fifteen individuals viewed Episode 5- *Place Matters* (53.6%). Four participants (14.3%) viewed Episode 6- *Collateral Damage*. Seventeen participants (60.7%) viewed Episode 7 - *Not Just a Paycheck*. Three participants stated that they did not remember which episode they viewed. One participant stated that they had watched Episode 5- *Place Matters* in a meeting and the rest on their own. This question was not answered by two survey participants.

Table 2

*Background*

	Percent	Count
<b>Organization</b>		
Virginia Heart Disease and Stroke Alliance	48.3%	14
Norfolk State University	3.4%	1
VDH/UVA Video Conference	6.9%	2
VDH, Tobacco Control Conf.	10.3%	3
The Fan Free Clinic	10.3%	3
Three Rivers Health District	10.3%	3
Henrico Health District	0	0
Other	10.3%	3
<b>Time</b>		
< THAN 1 MONTH	3.6%	1
1 MONTH- 6 MONTHS	60.6%	17

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6 MONTHS- 1 YEAR	17.9%	5
> THAN 1 YEAR	17.9%	5
Episode		
1- In Sickness and In Wealth	32.1%	9
2- When the Bough Breaks	21.4%	6
3- Becoming American	14.3%	4
4- Bad Sugar	17.9%	5
5- Place Matters	53.6%	15
6- Collateral Damage	14.3%	4
7- Not Just a Paycheck	60.7%	17
Other	14.3%	4

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Key Question 1/ What did participants think about the Health Equity Campaign presentations

*The presentation was well organized.* Out of the of the 27 responses to the statement, *The presentation was well organized*, no participants *Strongly Disagreed* and *Disagreed*. Two (7.4%) participants *Neither Agreed or Disagreed* to the statement. Twelve (14.4%) participants *Agreed*

to the statement. Thirteen (48.1%) participants *Strongly Agreed* to the statement. In averaging the ratings of the statement *The presentation was well organized*, the score was 4.41.

*The presentation was informative*. Out of the of the 27 responses to the statement, *The presentation was informative*, no participants *Strongly Disagreed* and *Disagreed* to the statement. Two (7.4%) participants *Neither Agreed or Disagreed* to the statement. Seven (25.9%) participants *Agreed* to the statement. Eighteen (66.7%) participants *Strongly Agreed* to the statement. In averaging the ratings of the statement, *The presentation was informative* the score was 4.59.

The presentation was overall beneficial to me. Out of the of the 27 responses to the statement, *The presentation was overall beneficial to me*, no participants *Strongly Disagreed* and *Disagreed* to the statement *The presentation was overall beneficial to me*. Three (11.1%) participants *Neither Agreed or Disagreed* to the statement. Nine (33.3%) participants *Agreed* to the statement. Fifteen (55.6%) participants *Strongly Agreed* to the statement. In averaging the ratings of the statement, *The presentation was overall beneficial to me* the score was 4.44.

*The presentation was a good use of my time*. Out of the of the 27 responses to the statement, *The presentation was a good use of my time*, no participants *Strongly Disagreed* and *Disagreed* to the statement. Three (11.1%) participants *Neither Agreed and Disagreed* to the statement. Ten (37.0%) participants *Agreed* to the statement. Fourteen (51.9%) participants *Strongly Agreed* to the statement. In averaging the ratings of the statement *The presentation was a good use of my time* the score was 4.41.

Table 3

*Key Question 1*

Answer Options	Percent	Count
The presentation was well organized		
1	0.0%	0
2	0.0%	0
3	7.4%	2
4	44.4%	12
5	48.1%	13
The presentation was informative		
1	0.0%	0
2	0.0%	0
3	7.4%	2
4	25.9%	7
5	66.7%	18
The presentation was overall beneficial to me		



1	0.0%	0
2	0.0%	0
3	11.1%	3
4	33.3%	9
5	55.6%	15

The presentation was a good use of my time

1	0.0%	0
2	0.0%	0
3	11.1%	3
4	37.0%	10
5	51.9%	14

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### Summary (Key Question 1)

The overall average pertaining to the evaluation level *Participants' reactions as to whether or not they were satisfied with the presentations or felt that they were relevant* and key question (*What did participants think about the Health Equity Campaign presentations*) was 4.46 out of 5. The highest scoring statement given to the statement , *The presentation was informative*

(4.59) followed by *The presentation was overall beneficial to me* (4.44), *The presentation was well organized* (4.41), and *The presentation was a good use of my time* (4.41).

Key Question 2/ What extent did the Health Equity Campaign meet its goal of getting participants to learn and become aware about health equity

*The presentation enabled me to understand a broader definition of health and health equity.* Out of the 27 responses to the statement, *The presentation enabled me to understand a broader definition of health and health equity* no participants *Strongly Disagreed* and *Disagreed* to the statement. One (3.7%) participant *Neither Agreed or Disagreed* to the statement. Thirteen (48.1%) participants *Agreed* to the statement. Thirteen (48.1%) participants also *Strongly Agreed* to the statement. In averaging the ratings of the statement, *The presentation enabled me to understand a broader definition of health and health equity* the score was 4.44.

*The presentation increased my understanding of the difference between health inequity, health inequality, and health disparities.* Out of the 27 responses to the statement, *The presentation increased my understanding of the difference between health inequity, health inequality, and health disparities*, no participants *Strongly Disagreed* and *Disagreed* to the statement. Two (7.4%) participants *Neither Agreed or Disagreed* to the statement. Fourteen (51.9%) participants *Agreed* to the statement. Eleven (40.7%) participants *Strongly Agreed* to the statement. In averaging the ratings of the statement *The presentation increased my understanding of the difference between health inequity, health inequality, and health disparities* the score was 4.33.

*The presentations increased my understanding of the meaning of the social determinants of health.* Out of the 27 responses to the statement, *The presentations increased my understanding of the meaning of the social determinants of health*, no participants *Strongly Disagreed* and *Disagreed* to the statement. One (3.7%) participant *Neither Agreed or Disagreed* to the statement. Thirteen (48.1%) participants *Agreed* to the statement. Thirteen (48.1%) participants also *Strongly Agreed* to the statement. In averaging the ratings of the statement *The presentations increased my understanding of the meaning of the social determinants of health* the score was 4.44.

*The presentation increased my awareness of health equity/inequity in the United States.* Out of the 27 responses to the statement, *The presentation increased my awareness of health equity/inequity in the United States*, no participants *Strongly Disagreed* and *Disagreed* to the statement. Three (11.1%) participants *Neither Agreed or Disagreed* to the statement. Ten (37.0%) participants *Agreed* to the statement. Fourteen (51.9%) participants *Strongly Agreed* to the statement. In averaging the ratings of the statement *The presentation increased my awareness of health equity/inequity in the United States* the score was 4.41.

*The presentation increased my awareness of health equity/inequity in Virginia.* Out of the 27 responses to the statement, no participants *Strongly Disagreed* to the statement, *The presentation increased my awareness of health equity/inequity in Virginia*. One (3.7%) participant *Disagreed* to the statement. Six (22.2%) participants *Neither Agreed or Disagreed* to the statement. Eleven (40.7%) participants *Agreed* to the statement. Nine (33.3%) participants *Strongly Agreed* to the statement. In averaging the ratings of the statement *The presentation increased my awareness of health equity/inequity in Virginia* the score was 4.04.

*The presentation increased my awareness of health equity/inequity in my neighborhood/community.* Out of the 27 responses to the statement, one participant (3.7%) *Strongly Disagreed* to the statement. Two (7.4%) participants *Disagreed* to the statement. Six (22.2%) participants *Neither Agreed or Disagreed* to the statement. Ten (37.0%) participants *Agreed* to the statement. Eight (29.6%) participants *Strongly Agreed* to the statement. In averaging the ratings of the statement *The presentation increased my awareness of health equity/inequity in my neighborhood/community* the score was 3.81.

Table 4

*Key Question 2*

Answer Options	Percent	Count
The presentation enabled me to understand a broader definition of health and health equity		
1	0.0%	0
2	0.0%	0
3	3.7%	1
4	48.1%	13
5	48.1%	13
The presentation increased my understanding of the difference between health inequity, health inequality, and health disparities		
1	0.0%	0
2	0.0%	0
3	7.4%	2
4	51.9%	14

5	40.7%	11
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The presentations increased my understanding of  
the meaning of the social determinants of health

1	0.0%	0
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2	0.0%	0
---	------	---

3	3.7%	1
---	------	---

4	48.1%	13
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5	48.1%	13
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The presentation increased my awareness of health  
equity/inequity in the United States

1	0.0%	0
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2	0.0%	0
---	------	---

3	11.1%	3
---	-------	---

4	37.0%	10
---	-------	----

5	51.9%	14
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The presentation increased my awareness of health  
equity/inequity in Virginia

1	0.0%	0
2	3.7%	1
3	22.2%	6
4	40.7%	11
5	33.3%	9

The presentation increased my awareness of health equity/inequity in my neighborhood/community

1	3.7%	1
2	7.4%	2
3	22.2%	6
4	37.0%	10
5	29.6%	8

### Summary ( Key Question 2)

The overall average pertaining to the evaluation level *The extent to which participants have improved or increased their knowledge as a result of the presentations* and key question *(To what extent did the Health Equity Campaign meet its goal of getting participants to learn*

*and become aware about health equity*) was 4.25 out of 5. The highest scoring statements were *The presentation enabled me to understand a broader definition of health and health equity (4.44)* , *The presentations increased my understanding of the meaning of the social determinants of health (4.44)* followed by *The presentation increased my awareness of health equity/inequity in the United States (4.41)* and *The presentation increased my understanding of the difference between health inequity, health inequality, and health disparities (4.33)*. The lowest scoring statements were *The presentation increased my awareness of health equity/inequity in Virginia (4.04)* and *The presentation increased my awareness of health equity/inequity in my neighborhood/community (3.81)*.

Key Question 3- What extent did the program meet its goal of getting participants and their organizations to advocate and take action towards health equity

*As a result of the presentation, I now discuss health equity with others.* Out of the 26 responses to the statement, *As a result of the presentation, I now discuss health equity with others*, one participant (3.8%) *Strongly Disagreed* to the statement. No participants *Disagreed* to the statement. Five (19.2%) participants *Neither Agreed or Disagreed* to the statement. Fourteen (53.8%) participants *Agreed* to the statement. Six (23.1%) participants *Strongly Agreed* to the statement. In averaging the ratings of the statement *As a result of the presentation, I now discuss health equity with others* the score was 3.92.

*As a result of the presentation, I am motivated to work to help solve the problems of health inequities.* Out of the of the 27 responses to the statement, *As a result of the presentation, I am motivated to work to help solve the problems of health inequities* no participants *Strongly Disagreed* and *Disagreed* to the statement. Four participants (14.8%) *Neither Agreed or*



*Disagreed* to the statement. Thirteen (48.1%) participants *Agreed* to the statement. Ten (37.0%) participants *Strongly Agreed* to the statement. In averaging the ratings of the statement *As a result of the presentation, I am motivated to work to help solve the problems of health inequities* the score was 4.22.

*I believe that the presentation has given my organization/myself the tools to take action to address the problems of health inequities.* Out of the of the 27 responses to the statement, *I believe that the presentation has given my organization/myself the tools to take action to address the problems of health inequities*, one participant (3.7%) *Strongly Disagreed*. One participant (3.7%) also *Disagreed*. Eight (29.6%) participants *Neither Agreed or Disagreed* to the statement. Twelve (44.4%) participants *Agreed* to the statement. Five (18.5%) participants *Strongly Agreed* to the statement. In averaging the ratings of the statement, *I believe that the presentation has given my organization/myself the tools to take action to address the problems of health inequities* the score was 3.70.

*As a result of the presentation, my organization/I have developed plans to take action in my neighborhood/organization/community to promote health equity.* Out of the of the 26 responses to the statement *As a result of the presentation, my organization/I have developed plans to take action in my neighborhood/organization/community to promote health equity* three participants (11.5%) *Strongly Disagreed*. Two (7.7%) participants *Disagreed*. Ten (38.5%) participants *Neither Agreed or Disagreed* to the statement. Six (23.1%) participants *Agreed* to the statement. Five (19.2%) participants *Strongly Agreed* to the statement. In averaging the ratings of the statement *As a result of the presentation, my organization/I have developed plans*

*to take action in my neighborhood/organization/community to promote health equity* the score was 3.31.

*As a result of the presentation, my organization/ I am now taking action in my neighborhood/organization/community to promote health equity* four participants. Out of the of the 27 responses to the statement, *As a result of the presentation, my organization/ I am now taking action in my neighborhood/organization/community to promote health equity* four participants (14.8%) *Strongly Disagreed*. One participant (3.7%) *Disagreed*. Nine (33.3%) participants *Neither Agreed or Disagreed* to the statement, and nine (33.3%) participants also *Agreed* to the statement. Five (14.8%) participants *Strongly Agreed* to the statement. In averaging the ratings of the statement *As a result of the presentation, my organization/ I am now taking action in my neighborhood/organization/community to promote health equity* the score was 3.30.

Table 5

*Key Question 3*

Answer Options	Percent	Count
As a result of the presentation, I now		
discuss health equity with others		
1	3.8%	1
2	0.0%	0
3	19.2%	5
4	53.8%	14
5	23.1%	6
As a result of the presentation, I am		
motivated to work to help solve the		
problems of health inequities		
1	0.0%	0
2	0.0%	0
3	14.8%	4
4	48.1%	13

5	37.0%	10
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I believe that the presentation has  
given my organization/myself the tools  
to take action to address the problems  
of health inequities

1	3.7%	1
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2	3.7%	1
---	------	---

3	29.6%	8
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4	44.4%	12
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5	18.5%	5
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As a result of the presentation, my  
organization/I have developed plans to  
take action in my  
neighborhood/organization/community  
to promote health equity

1	11.5%	3
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2	7.7%	2
---	------	---

3	38.5%	10
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4	23.1%	6
5	19.2%	5
<p>As a result of the presentation, my organization/ I am now taking action in my neighborhood/organization/community to promote health equity</p>		
1	14.8%	4
2	3.7%	1
3	33.3%	9
4	33.3%	9
5	14.8%	4

### Summary (Key Question 3)

The overall average pertaining to the evaluation level *Participants' behavior as a result of their new knowledge, attitudes, and beliefs within their current environment* and key question *To what extent did the program meet its goal of getting participants and their organizations to advocate and take action towards health equity* was 3.70 out of 5 . The highest scoring statement was *As*

*a result of the presentation, I am motivated to work to help solve the problems of health inequities (4.22) followed by As a result of the presentation, I now discuss health equity with others (3.92) and I believe that the presentation has given my organization/myself the tools to take action to address the problems of health inequities (3.70) The lowest scoring statements were As a result of the presentation, my organization/I have developed plans to take action in my neighborhood/organization/community to promote health equity (3.31) and As a result of the presentation, my organization/ I am now taking action in my neighborhood/organization/community to promote health equity (3.30).*

### Interview Responses

The following themes emerged from the interview responses 1) *Strengths and Weaknesses of the Health Equity Campaign*; 3) *New Knowledge, Attitudes, Beliefs, and Influences*; 4) *Changes, Plans, and Actions* (Appendix F).

Group/Organization. The eight key participants represented the following groups: Eastern Virginia Medical School Division of Community Health and Research -Department of Pediatrics (Asthma Coalition), Norfolk State University Department of Political Science, The Fan Free Clinic, Virginia Commonwealth University Center for Health Disparities, Virginia Department of Health Henrico Health District, Virginia Department of Health HIV Community Planning Committee, Virginia Department of Health Three Rivers Health District, and the Virginia Department of Health Virginia Heart Disease and Stroke Alliance.

Episodes Viewed. All of the participants have viewed at least all or part of the seven episodes of the documentary. Some participants indicated that have viewed several clips of the

*Unnatural Causes* documentary throughout the presentation and some have taken the initiative to view the entire documentary on their own after having received the presentations. Through the participants' responses, it is evident that the presentations were held at various gatherings. The presentation was given as part of a series of lectures, as a component to an annual conference, and in one instance as part of a "kick-off" event to a program that promoted wellness in mothers and infants. In many instances, however, staff members met together in small groups and participated in the presentation to discuss and address the issue of health equity.

Strengths. In commenting on the strength of the overall presentation, one participant mentioned, "The facilitation was good and I think that adds a lot to the film-to have knowledgeable facilitators who could guide the discussion and that was helpful... [the facilitators] were very knowledgeable." According to one participant, "The strength of the presentation was the wonderful source [the documentary]. This participant also felt that the documentary was "pretty convincing in a short time". Another strength of the presentation was that it tied well with the organization's mission, "[The presentation] was right on the eight ball with where we were," according to one participant. A strength of the documentary mentioned by one participant was that the episode "*When the Bough Breaks*" brought awareness to some of the causes of infant mortality in African American women that "people didn't really think about" such as what effect "stress has on the infant". One participant found that the main strength of the episode "*When the Bough Breaks*" was that it "fell well in line with our objectives and our target population", African Americans affected by infant deaths. One participant found that the "*Place Matters*" episode was the one that people "related" to the best. Also because this participant's organization was a policy organization it provided a "policy piece". It also targeted the

organization's target population which included children with asthma and those who resided in public housing facilities.

The foundation and structure of the documentary itself was seen as a strength to many participants. The format of the documentary was mentioned as a strength in that according to one participant it was "formatted ...so that it could be broken down into segments that were easy to deal with in the busy schedules that people have". According to one participant the documentary "played a part in people thinking outside tradition...conditions that you can't really see". One participant mentioned that the documentary provided, "compelling information, really made me think, and it was a good blend of both statistical factual information and people's real stories". Another point made by one participant was that the strength in the film lied in the sense that it "provided for a direct casual relationship between socioeconomic status, geographic location, residential location, and the decreases in the quality of health for low income minorities that live in those locations". It was the "causal connections" that were brought out in the documentary that he felt were most important. A common theme was that the documentary was "eye opening" to people not in the public health field. Furthermore, one participant stated that you "didn't need a Master of Public Health to understand it". He added that he has "went to several health departments and showed the documentary to office staff, to administrative people, to environmental health, to nursing all in one group...everyone was able to relate to the message." Another strength, he stated which added to the documentary's ability to be understood by all was that it used, "real life examples that were easy to follow and that there was science in it but it was not overwhelming. It was presented in a way that even a lay person could understand". One participant also felt that the documentary was an "emotional pull" which



enabled others to understand that this is something that “affects the whole community in the way that it impacts”. Many participants agreed that the interview itself was a strength to the overall presentation and served as a “reinforcement” on the issues and content of the presentations. This might have been true for some as it was a “while” since they had received the presentations. One participant stated that the interview questions and answers discussed was actually very helpful to “remind people that [the documentary and the content and issues of the presentation] exists and ... to use it for more than one time”.

Weaknesses. After viewing the documentary, there was a common theme by some participants of a general sense of feeling “left scratching our heads” about what can be done to change the issues. This was viewed as a challenge to a few of the participants. One participant mentioned that they felt that there were not enough people to talk to that could help with this challenge of what could be done. One participant mentioned that, “folks asked for more because they were left without a real sense of what to do”. The problem in the film to one participant seemed, “overwhelming” by not knowing what to do. That participant explained that , “ [their organization] can’t fix people’s housing, change their income, or get them better access to health insurance...the problem is so large”. It was also mentioned that what was presented in the documentary seemed like a “big societal issue and not something an individual program could really change”. The issue of the increase in African American infant mortality in “*When the Bough Break’s*” was also brought up as a weakness in addition to a strength. One participant stated that how “race affect the outcomes was a big leap...some people easily get it but some people thought it was an overly complex concept”. Another participant states, that “there are some people who don’t get it, see it, and get it and some people don’t get it, see it, and still don’t

get it”. That participant felt that something needed to be included in the presentation such as more “dialogue to help people understand how that dynamic works especially if they are not from a community of color”.

Knowledge, Attitudes, Beliefs, and Influences. One participant felt that because their organization already dealt with issues addressed in the documentary there was really “nothing surprising” in the film. However, after having viewed the “*Place Matters*” episode the participant was able to “see how difficult it could be for people who want to make healthy decisions to make them”. “*When the Bough Breaks*” has been used by one participating organization that was working on a research project to improve pregnancy outcomes as a way to “raise awareness about infant mortality on a national level and also in Richmond” to staff members working on the project.

One participant who was the director of one of the community health clinics indicated that their organization has changed their strategic plan and changed their mission statement to “include the word advocacy”. He indicated that they have become more explicit in delivering services in relation to health advocacy. One participant mentioned that an organization that he sat on used the presentation and documentary to restructure the organizations vision and mission statement. He stated, “We specifically wrote the mission and vision based on working to eliminate health inequality and inequities within women and children”. One participant stated that her organizations hasn’t been able to make any specific changes, however has found her organization using the “language more in terms of using disparities and health inequity rather than saying there’s racial differences but trying to link them more to overall inequities and

disparities”. One participant stated that her organization moved to “include health disparities as part of everything we do”.

A common theme very evident was that participating organizations that were not direct health related service providers have used the information gained from the presentations to relay information and show segments of the documentary in a community environment which included both patients and providers. After a presentation, one participant mentioned that a number of people did ask for more information so they in turn had a follow up presentation in particular on “what is being done in Richmond to decrease the infant mortality rate.” As a consequence of the presentation, one participant mentioned that he was able to “disseminate the information pertaining to health disparity and health equity throughout the community ...and campus community as well.” One organization has placed a link onto their website where others can view the documentary. They also sent the documentary out to community groups and organizations. Another organization stated that its’ main focus was on policy changes and therefore it used the documentary to “get the community to start talking about health inequity and ...understanding the social determinants of health, because it’s part of a bigger conversation that has to happen in the community and it’s part of increasing the communities understanding of the way we go about working and how it has to change”. For one organization, the presentation produced a “ripple effect” of receiving information then sharing it with others.

Changes, Plans, and Action. One organization was able to use the theme of *Place Matters* with Mobilizing for Action through Planning and Partnerships (*M.A.P.P.*) and other needs assessment to “link” with a foundation in the district. This team has been able to give

money to other organizations to study what they believe are causing the roots of poverty in the area rather than “giving money to organizations to just deal with symptoms”.

One organization viewed the presentation with management staff. They spent half a day viewing and discussing *Place Matters* and issues related to area and health and developed a document of issues that they could act on. Following the presentation, this participant, during national public health week, went to several public health departments and showed clips followed by a discussion on things that could be done in the community. This participant mentioned that these presentations were given to health departments as well as programs, therefore some presentations were given to staff, some to office managers, etc. Another organization also used the *Place Matters* segment as part of their annual meeting. After the presentation they discussed “root cause analyses” which is a way of taking an issue and trying to drill down to what is the real cause of the problem. They later divided the group into smaller groups to have them create their own root cause analyses. As an addition to the “*Place Matters*” presentation, one organization developed slides that put the ideas and themes of that episode into the context of the target audiences own community. They used pictures of homes, areas, stores etc. within the target area to get the message across. As part of that presentation, they engaged the audience in discussions such as how the life of a little girl would have been impacted by growing up in the different areas shown in the photos.

An organization which has a program addressing inequities in infant mortality in the African American community used the presentation as part of the “kick-off” for the start of their program. The program’s leader stated that, “we started the *Unnatural Causes* documentary to prove that the disparity does exist...we wanted people to observe this and act.” This

organization has used the presentation to reinforce outreach into an African American population in a select community that has been largely affected by infant mortality. This program offers community outreach and education and partners with community members such as church members who are also leaders in the community. The program's function, based on a theme touched on by professionals in the documentary, is to "inform, educate, and empower" the community as to what they need to know before, during, and after pregnancy. The program normally recruits about ten community members to become involved in the program at each session, however, the program director stated that, "After the presentation was shown we saw about thirty people wanting to train that night." This participant also mentioned that a key success of its program was partnering with other organizations in the state with the same goal adding, "It is crucial to work together as a team".

One participant stated that he and other members of his organization are currently working with the United States Department of Health and Human Services in creating "applied research methodologies to improve the quantitative as well as qualitative information base on health equity for much of the country". This methodology will include a number of features, "especially demographic features" that were discussed in the documentary. This method will largely be obtained through looking at socioeconomic status and other variables that may impact low income and minority communities around the country. Even though, the participant mentioned that this research effort served as a reinforcement in such areas as advocating for more research related efforts including comprehensive database grids, for example, that will be used to collect demographic and other information in order to "improve the description of health equity problems".

## Summary (Interviews)

Eight organization/group leaders completed interviews. These eight participants represented eight different organizations located in various parts of Virginia which have participated in the *Health Equity Campaign*. Interview responses were compared and contrasted and fell into the themes of *Strengths and Weaknesses; Knowledge, Attitudes, Beliefs, and Influences; and Changes, Plan and Actions*. Interviewed participants expressed that they had viewed various episodes of the documentary. There were a great number of varied and similar strengths attributed to the *Health Equity Campaign* by the participants. Participants also stated that the *Health Equity Campaign* did influence their knowledge and attitudes and they were able to make adjustments within their organizations and amongst other organization members who also received presentations. Some participants were able to give detailed examples on how they have been able to use the *Health Equity Campaign* to promote health equity in research, policy changes, and into their surrounding areas and communities. The issues addressed in the “*Place Matters*” episode were the ones in which participants seemed to be able to make changes and advocate the most. Many of weakness and needed additions to the *Health Equity Campaign* expressed by the participants, however, fell in the area of advocacy. Participants expressed a feeling of being unable to apply what they have learned through the campaign in the form of advocacy. Some participants were not sure how their knowledge could be used to make changes in their organizations programs and policy and specifically towards achieving health equity in their neighborhoods and communities. They felt that this was not a change their organization could do on their own or that their organization was already doing what they could in order to address the ideas discussed in the documentary.

## Chapter 5

### Summary, Conclusions, Recommendations

#### Summary

The purpose of this present study was to evaluate the impact of the Virginia Department of Health Office of Minority Health and Public Health Policy (OMHPHP) *Health Equity Campaign* on various individuals and organizations within Virginia. The research question asked was:

What impact has the *Health Equity Campaign* presentations had on enabling organizations and its members to incorporate a focus on health equity into their organizational policies, practices, and programs?

The research objectives were to:

1. To determine participant satisfaction with the presentations delivered as part of the Virginia Department of Health OMHPHP Health Equity Campaign.
2. To determine the Virginia Department of Health OMHPHP Health Equity Campaign's impact on increasing:
  - a) individual knowledge and awareness about health equity
  - b) individual and organizational advocacy and development of health equity intervention programs

3. To establish a list of recommendations for increasing knowledge, awareness, and advocacy of health equity.

Chapter four gives a representation of study participants and a detailed description about survey and interview responses. Chapter five makes an attempt to bridge the survey and interviews responses and to provide further insight into how these responses reflect the *Health Equity Campaign* and affect achieving health equity in Virginia.

Participants represented various occupations, age groups, organizations and places of residence within Virginia. There was a broad range of uses of the “Unnatural Causes..Is Inequality Making Us Sick?” documentary by the participants as a result of the *Health Equity Campaign*. The highest scoring survey statement out of all of the fifteen statements was *The presentation was informative (4.59)*. The statement *The presentation was informative* was used to evaluate the key question *What did participants think about the Health Equity Campaign presentations?*. The lowest scoring statements out of all of the fifteen statements were *As a result of the presentation, my organization/I have developed plans to take action in my neighborhood/organization/community to promote health equity (3.30)* and *As a result of the presentation, my organization/ I am now taking action in my neighborhood/organization/community to promote health equity (3.30)*. These statements *As a result of the presentation, my organization/I have developed plans to take action in my neighborhood/organization/community to promote health equity* and *As a result of the presentation, my organization/ I am now taking action in my neighborhood/organization/community to promote health equity* were used to evaluate the key question *To what extent did the program meet its goal of getting participants and their*



*organizations to advocate and take action towards health equity?*. The mean scores given to the key questions; *What did participants think about the Health Equity Campaign presentations?*, *To what extent did the Health Equity Campaign meet its goal of getting participants to learn and become aware about health equity?*, and *To what extent did the program meet its goal of getting participants and their organizations to advocate and take action towards health equity?* were 4.46, 4.25, and 3.70 respectively. Interviewed participants expressed strengths in the *Health Equity Campaign* organization, structure, and purpose and in the knowledge and information that they had gained from the presentations. Many were able to tie this new knowledge in with their organizations mission and purpose. Most of the advocacy was done in conjunction with the “Place Matters” episode of “Unnatural Causes..Is Inequality Making Us Sick?”.

## Conclusions

This study showed that participants did benefit greatly from the *Health Equity Campaign* through it being overall informative and beneficial to all those who participated. The *Health Equity Campaign* enabled many participants to increase their knowledge and awareness about health equity. The *Health Equity Campaign* furthered allowed participants, within their organizations, to understand and reflect on the issues contributing to and impacting health equity.

Overall, both surveyed and interviewed participants thought very highly of the way the presentation was structured and felt that they were informed and gained knowledge and awareness about health equity from the presentations. In many cases, however, they did not take further action towards advocacy. Most participants did not advocate for health equity in their community, organizations, or neighborhoods. This incidence was exemplified in the survey responses. The highest scoring statements out of the 15 survey statements belonged to the key

questions *What did participants think about the Health Equity Campaign presentations* and *To what extent did the Health Equity Campaign meet its goal of getting participants to learn and become aware about health equity* and the lowest scoring statements out of the 15 survey statements belonged to the key question *To what extent did the program meet its goal of getting participants and their organizations to advocate and take action towards health equity*. The information gathered from the interview provided a more detail insight on why this incidence occurred. Many participants during their interview stated that although they gained a great deal of knowledge and were able to raise education and awareness in their own organizations they did not feel equipped in their own fields to go out and advocate to the outside world. “Place Matters” served as a good model to advocate for health equity to outside members of an organization such as in the community.

An important factor to consider in viewing the impact of the presentations and the *Health Equity Campaign* is that although a number of participants stated that they were uncertain about the specific changes that they could make to change the issues addressed in the documentary, many of these organizations were already created to address some of the same issues in the documentary such as asthma, infant mortality, and aiding socioeconomic disadvantaged populations; even though they previously before receiving the presentations and viewing the documentary might not have used or been aware of the “language” and “connections” depicted in the documentary . Therefore, the *Health Equity Campaign* presentations and the documentary, *Unnatural Causes...Is Inequality Making Us Sick?*, served as a very successful reinforcement to their goals and missions.

In order to achieve health equity in neighborhoods, communities, and Virginia, everyone involved should feel equipped to advocate for what they believe is fair and just. Just having the education and awareness about issues of health equity does not allow others to work together to make efforts to advocate for health equity. A health equity model has been created as a result of this study. In order to achieve health equity, a continuous cycle, focused around health equity needs to occur through structured programs and intervention; education and awareness; and advocacy. (Appendix G) There needs to be a balance between structured health equity interventions such as the *Health Equity Campaign, Education and Awareness* through these interventions, and *Advocacy* into communities, organizations, and legislation. Health equity interventions such as the *Health Equity Campaign* should provide accountability for working toward achieving health equity. The education and awareness gained through the *Health Equity Campaign* and similar interventions should also provide the tools needed to advocate for health equity. As a result, advocating for health equity through organizations, policy, and legislation will in turn be used to promote changes towards health equity and more programs and interventions similar to the *Health Equity Campaign* where needed.

Since the completion of this study, the name of the Virginia Department of Health Office of Minority Health and Public Health Policy was changed to the Office of Minority Health and Health Equity and the name of the Division of Health Equity was changed to the Division of Multicultural Health and Community Engagement. The *Health Equity Campaign* has also now developed into as the *Health Equity Initiative*. These changes further demonstrate the emphasis that is being placed on achieving health equity.

This study showed that the Virginia Department of Health *Health Equity Campaign* impacted its recipients by providing a vast amount of knowledge and awareness on health equity and the issues contributing to inequities in health. The *Health Equity Campaign* presentations and encompassing “Unnatural Causes ...Is Inequality Making Us Sick” documentary inspired and motivated participants to want to take action and discuss issues related to health equity within their groups, organizations, and institution. An effective way to transform education and awareness to advocacy to neighborhoods, communities, and policy is a component that needs to be strengthened in the *Health Equity Campaign*.

The *Health Equity Campaign* and its use with the ““Unnatural Causes ...Is Inequality Making Us Sick” documentary has been adapted by numerous organizations, agencies and institutions across the nation. While the number of participants in this study may have been small, participants represented varied occupations, organizations, and sectors within the Virginia Department of Health and other health infrastructures within Virginia. The methods used and findings of this study may be applied to other organizations who have used the health equity campaign or similar interventions in order to strengthen their efforts to promote health equity.

Overall, the *Health Equity Campaign* has been a very positive influence toward reaching the overarching goal of achieving health equity in Virginia. With the continuation of practice and development, the *Health Equity Campaign* presentations and related interventions will transform an intervention which through this study has proven to be successful in educating and raising awareness to Virginia’s health community about the issue of Health Equity into one that empowers all Virginians with the ability to become advocates for health equity and eliminate health inequities that are present. In the words of Dr Martin Luther King, “Injustice anywhere is

a threat to justice everywhere”. Working to eliminate health inequity through programs such as the *Health Equity Campaign* in Virginia will not only benefit Virginia, but can become a part of collaborative effort around the nation and globally to critically become aware of inequities as they occur, and as a result, reinforce the policies and structures needed to successfully and effectively achieve health equity.

Recommendation for Future Research:

- 1) Include lay persons such as various community members not belonging to a health sector in Virginia.
- 2) Include a broader sample size from a larger number of groups and organizations within Virginia in order to generalize findings.
- 3) Understand how the lesbian, gay, transgender, bisexual, and questioning (LGTBQ) community in Virginia are impacted by health inequities as this community has a high rate of specific diseases and are also affected by specific social determinants of health.
- 4) Determine how the new Health Care Reform has impacted efforts of achieving health equity in Virginia.
- 5) Implement this study in other areas of the United States and with other organizations across the nation who have adapted the *Health Equity Campaign*.
- 6) Use this research model to conduct a longitudinal study to progressively follow an individual organization or multiple organizations over a number of years through first

receiving the health equity presentation to how they have used the presentation and acted to impact local communities and government.

7) Conduct a longitudinal study to compare and contrast the findings of multiple organizations over time.

8) Include in the study possible solutions to promote advocacy of health equity and (as a part of advocacy) what can be done to eliminate health inequities.

9) Evaluate how different groups and organizations merge and work together after learning and implementing strategies of health equity in their own organizations.

10) Measure the impact that working together to achieve health equity might have.

#### Recommendations for Achieving Health Equity in Virginia:

The following recommendations for achieving health equity in Virginia were derived from this study, the interview responses, and the model created in this study to achieve health equity.

Health Equity Campaign. 1) The Health Equity Campaign should be structured to provide accountability, organization, and direct follow up to Health Equity efforts.

An intervention such as the *Health Equity Campaign* should be used to provide accountability to health equity in a given area. An organized system and database should be created in order to list and monitor organizations who received presentations and monitor changes and advocacy in their organizations, communities, neighborhoods etc. This database should also include perceived threats to health equity and other experiences and beliefs by participants. The database should be available to all participants and residents in Virginia in

order that everyone can see what they can do to play a part in achieving health equity. Reinforcement and direct follow up should be provided through phone calls, internet surveys, mailings, and meetings with the Virginia Department of Health Office of Minority Health and Health Equity.

Education and Awareness. 2) Presentations should be formatted around “Unnatural Causes... Is Inequality Making Us Sick?” but also tailored to the specific organization, and target population using real life examples that hit close to home.

Presentations should be structured around the “*Unnatural Causes...Is Inequality Making Us Sick?*” documentary. They should be formatted in a way to coincide with the seven episodes of the *Unnatural Causes* documentary. In addition to the documentary, additional features that can be added to presentations to help facilitate discussions and create solutions include: learning objectives discussed at the beginning of the presentations and root cause analysis immediately following. “Link” the presentation to the target group. Presentations should be tailored to each organization and target group by including graphics and specific data to enhance the themes, ideas, and issues addressed in the presentation. Experts and leaders from other organization who are currently addressing the issue that is at hand and who have already created or implemented successful interventions to promote health equity and address the problems of inequities in their communities and organizations should be invited to speak at the presentations.

3) Through continuous discussion, background information and more insight into problems and health inequity issues should be provided as an instrumental component to presentations.

Provide background information on the issues at hand such as those dealing with the Social Determinants of Health and the Social Determinants of Equity. For example, a discussion on racism and the general impact that it may have on individuals. Give others the opportunity to discuss how they feel about racism and how it has impacted them. Conduct ongoing meetings and group discussions to give individuals time to digest and “get” the information and then return with feedback, thoughts, ideas, and solutions.

4) An updated version or an addition to “Unnatural Causes...Is Inequality Making Us Sick?” needs to be created with relevant information addressing current issues and possible solutions.

A more updated version of the documentary needs to be created and implemented as an educational tool. Using mass media and current technology, the documentary should be made accessible to a wider audience. As stated by one participant, “A lot of people don’t listen to PBS”. The updated documentary should address broader socioeconomic disadvantaged populations not discussed in the original documentary. The documentary should also include the impact of the social determinants of health on infant and children’s health. Each episode should address how the inequity in our healthcare system impacts infants and children as well as adults. Most importantly, the documentary should include possible solutions. While not every problem may have the same solution, proposed methods to addressing health equity and solving the problems of health inequities should be added as an instrumental component to the documentary.

Advocacy. 5) Encourage collaborative efforts between all citizens of Virginia in order to work together to achieve health equity.



Organizations and groups should work collaboratively and together as a “team” with other organizations in the community, district, or commonwealth to brainstorm and come up with solutions to common and related problems. This means including all members of a community and not just health professionals, such as community leaders, law enforcement, and political makers so that ideas and solutions can be transformed into action.

Evaluation. 6) Evaluation should be conducted for all components of health equity; Intervention, Education and Awareness, and Advocacy.

Evaluations should be conducted for all components of achieving health equity discussed in this study’s model; Intervention, Education and Awareness, and Advocacy. Structured evaluations similar to the evaluation conducted in this study should be used to measure the overall intervention, knowledge and attitudes gained, and programs and policies that are put in place to promote health equity.

7) Evaluation should be performed as a continuous cycle.

Similar to the model in achieving health equity, evaluations should be conducted on a continuous bases and immediately following each component of the cycle; Intervention, Education and Awareness, and Advocacy. In this way evaluations will not only be used to determine impact and effectiveness but can also provide reinforcement to themes, issues, and the overall goal of working towards health equity.

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Appendix A  
Recruitment Letter

Dear Virginia Department of Health Office of Minority Health and Public Health Policy (VDH OMHPHP) Health Equity Campaign Participant:

You are being invited to participate in an interview to evaluate and follow up on your participation in presentations that were a part of the VDH OMHPHP Health Equity Campaign. Anika Richards, a student who is working in collaboration with OMHPHP, is administering the surveys as part of her doctoral research. In addition, please forward the link below to an online survey to members of your organization. The interview is expected to take 30-50 min and the survey is expected to take approximately 15-30 min.

The results of this study will be interpreted and used to guide future health equity initiatives within OMHPHP.

[https://www.surveymonkey.com/s/Health\\_Equity](https://www.surveymonkey.com/s/Health_Equity)

Thank you for your time and consideration.

Sincerely,

Research Investigator

## Appendix B

### Informed Consent

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Informed Consent for Participants

in Research Projects Involving Human Subjects

Title of Project

Investigator(s)

#### I. Purpose of this Research/Project

The purpose of this research is to evaluate the impact of the presentations on the documentary “Unnatural Causes: Is Health Inequality Making Us Sick?” offered by the Virginia Department of Health Office of Minority Health and Public Health Policy (OMHPHP) on various individuals and organizations within Virginia. The research will evaluate health equity awareness, knowledge, and advocacy within participants and organizations. There will be approximately 100 participants either surveyed or interviewed in this research. Participants have been chosen on the basis that they have participated in the Office of Minority Health and Public Health Policy (OMHPHP) presentations on the documentary “Unnatural Causes: Is Health Inequality Making Us Sick?” at various points in time. This research is conducted as part of a dissertation for a Virginia Tech doctoral candidate. The results of this research will be used mainly for the purposes of writing this dissertation.

#### II. Procedures

You are asked to complete the attached survey and/or participate in the following interview to the best of your ability. Your responses to this survey will be recorded and compiled to appropriately assess the impact of the presentations you received as part of the Virginia Department of Health Office of Minority Health and Public Health Policy (OMHPHP) Health Equity Campaign. Your responses will also serve to assist in creating a list of recommendations to further address the issue of health equity within Virginia. Survey and interviews will be completed once by the participant and are estimated to take approximately 20-60 minutes.

#### III. Risks

There are no perceived risks for completing this survey or participating in the interview.

#### IV. Benefits

Once the results are analyzed participants will receive the benefits of a further understanding of how to achieve health equity within groups, organizations, communities, etc. There is no promise or guarantee of benefits that have been made to encourage you to participate. You may contact the researcher at a later time for a summary of the research results.

#### V. Extent of Anonymity and Confidentiality

All research participant identity will be kept confidential by the Virginia Department of Health Office of Minority Health and Public Health Policy (OMHPHP). This will be accomplished by keeping results stored in a highly secure area within the Virginia Department of Health Office of Minority Health and Public Health Policy (OMHPHP). For the purposes of accurate transcription, participant interviews will be tape recorded. Tapes will be secure and stored within the Virginia Department of Health Office of Minority Health and Public Health Policy (OMHPHP) and transcribed and scored by the research investigator. At no time will the researchers release the results of the study to



anyone other than individuals working on the project without your written consent". It is possible that the Institutional Review Board (IRB) may view this study's collected data for auditing purposes. The IRB is responsible for the oversight of the protection of human subjects involved in research.

#### VI. Compensation

There is no compensation for the completion of this survey.

#### VII. Freedom to Withdraw

You are free to withdraw from this study at any time or not complete portions of the survey or interview without penalty. You are free not to answer any questions that you choose without penalty.

#### 1. VIII. Subject's Responsibilities

I voluntarily agree to participate in this study.

I have read the Consent Form and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent:

Should I have any pertinent questions about this research or its conduct, and research subjects' rights, and whom to contact in the event of a research-related injury to the subject, I may contact:

Kerry Redican, Ed.D., MPH (540) 231-5743/kredican@vt.edu  
 Investigator/Faculty Advisor Telephone/email  
 David M. Moore(540)-231-4991/moored@vt.edu\_  
 Chair, Virginia Tech Institutional Review  
 Board for the Protection of Human Subjects  
 Office of Research Compliance  
 2000 Kraft Drive, Suite 2000 (0497)  
 Blacksburg, VA 24060

VIII. Subject's Responsibilities I voluntarily agree to participate in this study. I have read the Consent Form and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent: Should I have any pertinent questions about this research or its conduct, and research subjects' rights, and whom to contact in the event of a research-related injury to the subject, I may contact: Kerry Redican, Ed.D., MPH (540) 231-5743/kredican@vt.edu Investigator/Faculty Advisor Telephone/email David M. Moore(540)-231-4991/moored@vt.edu\_ Chair, Virginia Tech Institutional Review Board for the Protection of Human Subjects Office of Research Compliance 2000 Kraft Drive, Suite 2000 (0497) Blacksburg, VA 24060 I acknowledge that I have received and read the informed consent.

## Appendix C

## Likert Scale Statements (Online Survey)

1=Strongly Disagree 2=Disagree 3=Neither Agree or Disagree 4=Agree 5=Strongly Agree

1. The presentation was well organized.

- 1       2       3       4       5

2. The presentation was informative.

- 1       2       3       4       5

3. The presentation was overall beneficial to me.

- 1       2       3       4       5

4. The presentation was a good use of my time.

- 1       2       3       4       5

5. The presentation enabled me to understand a broader definition of health and health equity.

- 1       2       3       4       5

6. The presentation increased my understanding of the difference between health inequity, health inequality, and health disparities.

- 1       2       3       4       5

7. The presentations increased my understanding of the meaning of the social determinants of health.

- 1       2       3       4       5

8. The presentation increased my awareness of health equity/inequity in the United States.

- 1       2       3       4       5

9. The presentation increased my awareness of health equity/inequity in Virginia.

- 1       2       3       4       5

10. The presentation increased my awareness of health equity/inequity in my neighborhood/community.

- 1       2       3       4       5

11. As a result of the presentation, I now discuss health equity with others.

- 1       2       3       4       5

12. As a result of the presentation, I am motivated to work to help solve the problems of health inequities.

- 1       2       3       4       5

13. I believe that the presentation has given my organization/myself the tools to take action to address the problems of health inequities.

- 1       2       3       4       5

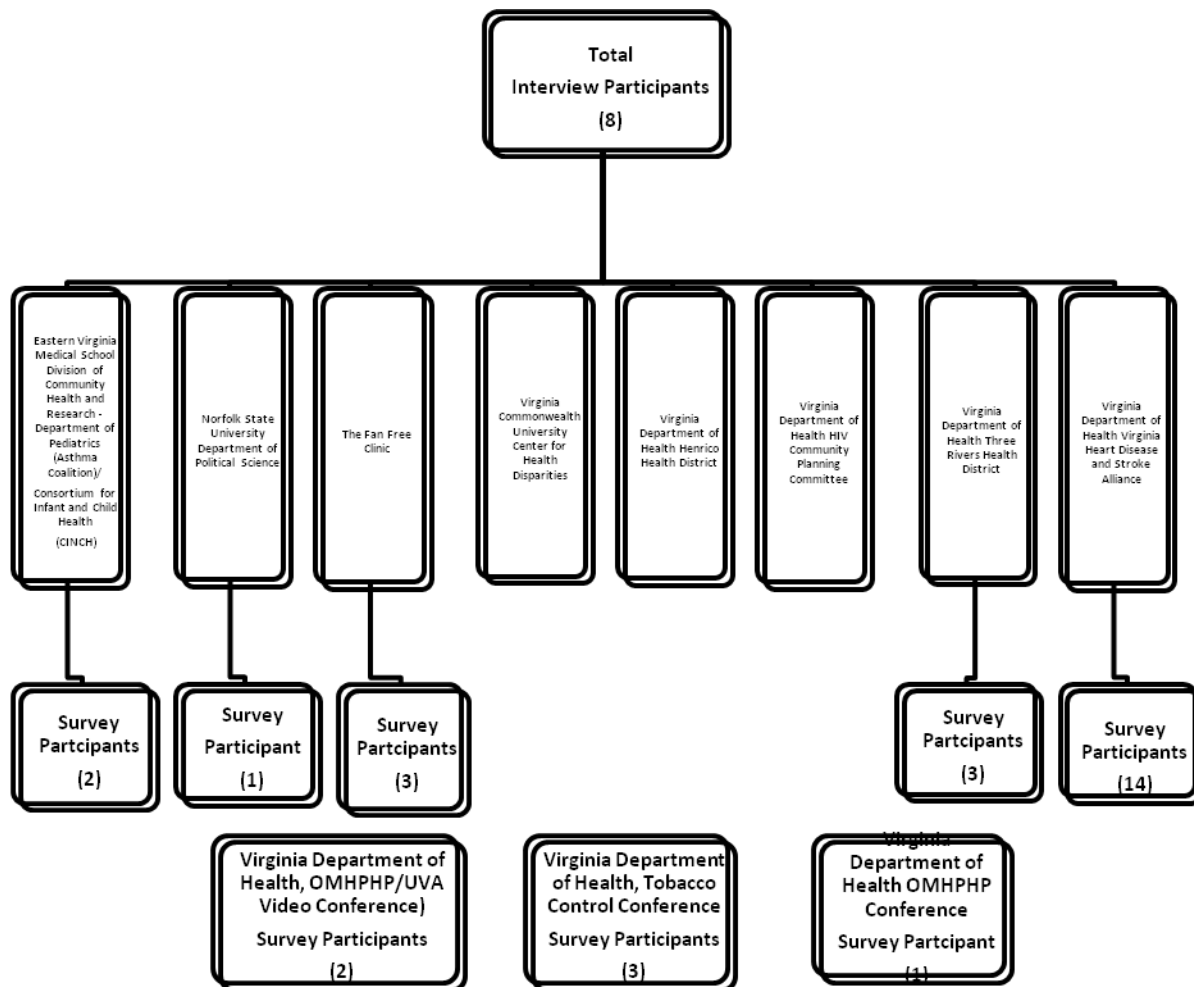
14. As a result of the presentation, my organization/I have developed plans to take action in my neighborhood/organization/community to promote health equity.

- 1       2       3       4       5

15. As a result of the presentation, my organization/ I am now taking action in my neighborhood/organization/community to promote health equity.

- 1       2       3       4       5

## Appendix D Participant Flow Chart



Appendix E  
Interview Responses

<b>Health Equity Campaign</b> <i>Strengths and Weakness</i>		<b>Education and Awareness</b> <i>Knowledge, Attitudes, Influences, and Beliefs</i>	<b>Advocacy</b> <i>Changes, Plans, and Actions</i>
“the facilitation was good and I think that adds a lot to the film-to have knowledgeable facilitators who could guide the discussion and that was helpful... [the facilitators] were very knowledgeable.”	“left scratching our heads”	“see how difficult it could be for people who want to make healthy decisions to make them”	“link” <i>Place Matters</i> with Mobilizing for Action through Planning and Partnerships (M.A.P.P.)
“the strength of the presentation was the wonderful source [the documentary].	“folks asked for more because they were left without a real sense of what to do”	“raise awareness about infant mortality on a national level and also in Richmond”	“[stopped]giving money to organizations to just deal with symptoms”
“pretty convincing in a short time.”			
“[before viewing the documentary] people didn’t really think about... the effect stress has on the infant”	“ [our organization] can’t fix people’s housing, change their income, or get them better access to health insurance...the problem is so large”	“include the word advocacy” into mission statement	“root cause analyses”
“fell well in line with our objectives and our target population”	“big societal issue and not something an individual	“we specifically wrote the mission and vision based on working to eliminate health	“used [the presentation] as part of our kick-off”

	program could really change”	inequality and inequities within women and children”	
“[provided a]policy piece”	“ [how] race affects the outcomes was a big leap...some people easily get it but some people thought it was an overly complex concept”	“used language more in terms of using disparities and health inequity rather than saying there’s racial differences but trying to link them more to overall inequities and disparities”	“we started [showing the documentary] to prove that the disparity does exist...we wanted people to observe this and act.”
“formatted ...so that it could be broken down into segments that were easy to deal with in the busy schedules that people have”	“there are some people who don’t get it, see it, and get it and some people don’t get it, see it, and still don’t get it	“include health disparities as part of everything we do”	used to “inform, educate, and empower” the community
“played a part in people thinking outside tradition...conditions that you can’t really see”	“[needs more] dialogue to help people understand how that dynamic works especially if they are not from a community of color”.	“disseminate the information pertaining to health disparity and health equity throughout the community and campus community as well”	“after the presentation was shown we saw about thirty people wanting to train that night”
“compelling information, really made me think, and it was a good blend of both statistical factual information and people’s real stories”		"get the community to start talking about health inequity and ...understanding the social determinants of health, because it’s part of a bigger conversation that has to happen in the community and it’s part of increasing the communities understanding of the way we go about working and how it has to	“it is crucial to work together as a team”

		change”	
“provided for a direct casual relationship between socioeconomic status, geographic location, residential location, and the decreases in the quality of health for low income minorities that live in those locations”		“ripple effect”	“applied research methodologies to improve the quantitative as well as qualitative information base on health equity for much of the country”
“causal connections”			“improve the description of health equity problems”
“eye opening”			
“went to several health departments and showed the documentary to office staff to administrative people, to environmental health, to nursing all in one group...everyone was able to relate to the message.”			
“real life examples that were easy to follow and that there was science in it but it was not			

overwhelming” “was presented in a way that even a lay person could understand”			
“emotional pull”			
“affects the whole community in the way that it impacts”			
“[served as a] reinforcement”			
“reminder that [the content and issues of the presentations] should be used for more than one time”			



## Appendix F

Health Equity Cycle Model. Shows continuous cycle needed between Intervention, Education and Awareness, and Advocacy.

