Framing with Data

When framed effectively, a compelling statistic can help people understand a topic more deeply. But too often, public health communicators use data in ways that fall flat or send messages we don't intend.

Here are a few framing guidelines to keep in mind when you are using numbers.

---

1. Order Matters.

Many of us were trained to start a paper or presentation with background data. There are good reasons to rethink this habit. *Order matters*: what comes first has a strong priming effect, influencing how people interpret what follows. If we start out with a lot of data without cues for how to interpret it, we leave room for people to misinterpret it. If we highlight a disparity among groups without explaining its cause, people often fall back on stereotypes or misconceptions to explain it for themselves.

The framing fix: First, state a clear message, then bring in data to back it up.

One way to do this is to express an aspirational goal or value that you'd like people to have in mind when they hear your data. Another way is to help people understand how things should work—and what's not working—before presenting any data. For instance, when talking about a health disparity, be sure to explain "how it happens" before talking about "who it happens to more often." Explain the foundations of community health (e.g., safe housing, quality education, nutritious food) as universal needs before showing that, for some communities, those needs are not being met.

(**Pro tip:** If you can't highlight a heading or sentence that states what you want people to take away from a statistic, keep working.)

---

2. Less is more.

If we stack up statistics to emphasize the severity of a problem, we're more likely to spark overwhelm than action. When we reduce the quantity of numbers we share, we increase people's ability to think them through. We also give ourselves room to offer some context and help people understand what it all means.

The framing fix: Treat your data like a curator treats art.

Be selective. Don't communicate with data just because you have it. Only include a number if it's the best support for a larger point. Spend time and effort on presenting it elegantly. Can you rewrite a graph's title so it tells the audience how to interpret the trend? Can you arrange the data to clarify the story it tells?

3. Highlight structures, not struggles.

Numbers can carry authority, so it's important to use them to convey the ideas that are essential to a public health analysis and mindset. When we only share data on negative health behaviors or health burdens, we risk reinforcing the myth that poor health comes from poor choices, and we miss opportunities

The framing fix: Share data points that help people see the need to fix systems, not people.

Lean toward and seek out data that illustrate upstream causes. Limit numbers on downstream consequences. For example, illustrate disparities in health care *access* rather than disparities in health *outcomes*. Present information about environmental exposures or shortcomings—tobacco advertising, unlit sidewalks, lack of grocery stores—rather than sharing data about health problems in isolation. When we show that a problem lies in a policy or system that humans designed, we imply that they can be *re*designed to work better.

⊗ Framed with Health Burdens or Behaviors	✓ Reframed with Health Environments
In Georgia, one in five students has untreated oral disease. More than half of our state's third-graders children have had a dental caries experience (cavity).	→ Only 9% of dentists in Georgia accept the dental insurance that covers 58% of children in the state.
Compared to their straight peers, twice as many young people who are lesbian, gay, or bisexual have smoked a cigarette before the age of 13. The rates are even higher for young LGBT+ people of color.	→ Young people who are LGBT+ report high levels of stress from discrimination. The connection between stress and smoking helps to explain why, when compared to straight peers, twice as many LGBT+ youth have tried a cigarette before the age of 13.
Despite more smoking cessation attempts, African Americans are less successful at quitting than white and Hispanic cigarette smokers, possibly because of lower utilization of cessation treatments such as counseling and medication. National research indicates that Black smokers are more likely than whites to call a tobacco quitline, yet less likely to enroll in a program or quit smoking as a result.	→ The experience of discrimination can make people reluctant to get medical care. One in three Black adults says they have experienced racial discrimination at a doctor's office. Many report avoiding seeking medical care as a result. This helps explain why Black smokers are more likely than whites to call a tobacco quitline, yet less likely to enroll in a program or quit smoking as a result.