International Journal of
Communication and Public Relations
(IJCPR)

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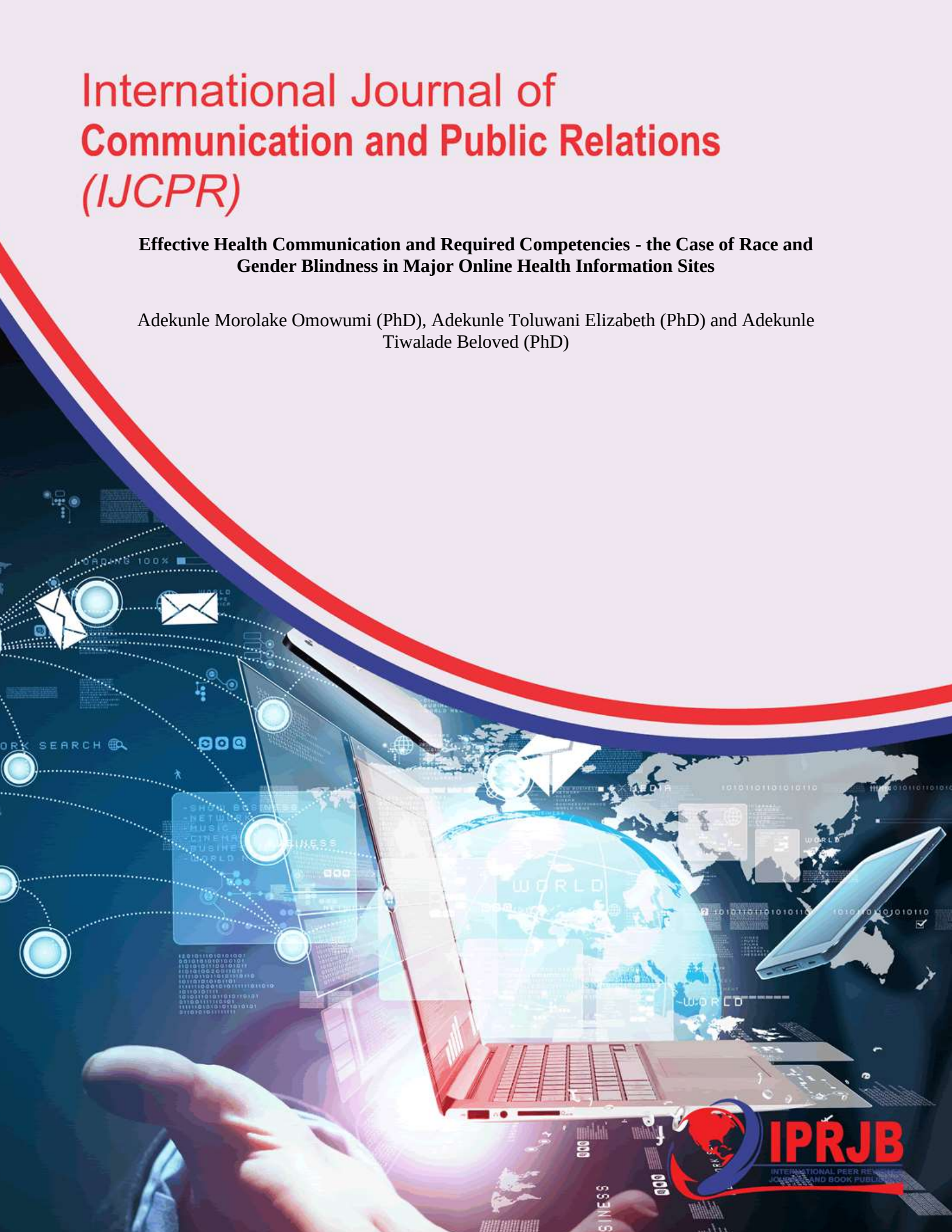

International Journal of Communication and Public Relation
ISSN 2520-7989 (Online)
Vol.8, Issue 3, No. 3, pp 28-35, 2023

www.iprjb.org

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Article History

Received 27th June 2023

Received in Revised Form 10th July2023

Accepted 21st July 2023

How to cite in APA format:

Adekunle, O., Adekunle, . E., & Adekunle , B. (2023). Effective Health Communication and Required Competencies - the Case of Race and Gender Blindness in Major Online Health Information Sites. *International Journal of Communication and Public Relation*, *8*(3), 28–35. https://doi.org/10.47604/ijcpr.2038

Abstract

Purpose: The aim of the study was to examine effective health communication and required competences in addressing race and gender blindness in major online health information sites

Methodology: This study explored 8 online health information sites to examine their sensitivity to race and gender. The sites were searched for different health issues, some of the health issues present differently for people with different racial descents while some present differently for males and females.

Findings: Results from this study showed that 4 out of 8 sites had content only in English Language; 2 had content in 2 different languages; 1 had content in 4 languages, and 1 in 5 Languages. These sites made no gender distinction in the description of some diseases known to manifest differently by gender such as sexually transmitted infections and some of the sites made no racial distinction in the description of some diseases such as asthma and diabetes with different prevalence and fatality rate for people of different racial descents. All the sites used white people to illustrate disease conditions, including skin conditions whose coloration would differ for different skin colors. Blindness to these diversities would only result in failure to meet health information needs of the target audience. Health information must be sensitive to diversities.

Unique Contribution to Theory, Practice and Policy: The study recommends that there is a need to make information sensitive to diverse racial, cultural, gender and individual groups. It also recommends that more studies should be done on impact that underrepresentation of race, gender, and cultural diversity has on the receipt of health information being communicated by these sites.

Keywords: *Online Health Information Sites, Gender Sensitivity, Racial Sensitivity, Consumers, Diversity*

INTRODUCTION

As the world is confronted with ever-increasing health challenges, people, more than ever before, need detailed, authentic and comprehensible information about health issues. Definitions of health communication highlight the concept as inclusive of strategies that aim to change behaviors and influence health decision making among a target population, during a specific period of time (Schiavo, 2013; Clift & Freimuth, 1995; Thomspon, 2014), Health communication strategies may be utilized in providing people with the necessary information that can positively impact their health outcomes (U.S. Department of Health and Human Services (DHHS,2022) According to the Centers for Disease Control and Prevention (CDC), health communication and social marketing, though different in certain ways, share common goals of changing attitudes, beliefs, and behaviors. This is achieved through creating and using products, programs, or interventions as means to the end of promoting health changes in individuals and communities (CDC, 2011).

Health communication has taken on more significant dimensions than ever as individuals and communities seek to understand health issues that they encounter while health providers and managers, seek to achieve behavioral change in their target populations for health promotion. Verbal and non-verbal modes of communication are employed in health communication. The verbal involves the use of words in oral and written communication, while the non-verbal involves the use of graphic and pictorial representations. In health communication, it is important to identify the problem; identify the intervention objectives; analyze and segment the target audience; develop and pretest the message ideas; select communication channels; choose, create and pretest the messages and products; develop a promotion plan; implement communication strategies and conduct process evaluation; and conduct outcome an outcome and impact evaluation (CDC, 2011).

The end goal of communication is the attainment of common understanding between the source and the target audience. The onus is on the initiator of a communication event to employ all available means to achieve their goal.

Theories of Health Communication

Communication theories of persuasion have informed health campaign related theories while interpersonal, nonverbal, and organisational communication theories have informed provider-patient theories of health communication. Generally, health communication theories have their roots in various theories of communication which have been well adapted to the health communication field.

The Health Belief Model

According to this model, there is a likelihood that an individual will adopt a health-related behavior according to the person's belief or perception of the illness and their thoughts on the effectiveness of treatment for that illness. If an individual perceives themselves to be vulnerable to a disease and they hold the belief that it is serious and preventable, that individual is more likely to adopt the recommended behavior necessary to either prevent or treat the illness. Health communication working in line with this theory, confront their audience with the risk factors for a disease and the necessary avoidance behavior ().

Theory of Planned Behavior (TPB)

This theory which has become very dominant in the field of health communication, is a modified version of the theory of reasoned action (TRA) (Ajzen and Fishbein 1980), with the additional variable of perceived behavioral control added. TRA proposed that an intervention targeting change in behavior should focus on beliefs, as these influence attitudes and expectation which influence intentions and behaviors. In addition to intention, the theory of planned behavior predicts that people will act on their intentions when they have the necessary skills for performing the behavior; so the element of perceived behavior control was added and the TRA was revised to the theory of planned behavior (TPB) (Rutter and Quine 2002, Ajzen 1991, Corcoran 2007).

According to the TPB, the greatest determinant of behavior is the intention either to perform or not to perform the behavior and intention is determined by three factors which are:

Attitude which results from weighing the pros and cons of performing the behavior, subjective norm which results from social pressure from significant others like family, friends and the media and perceived behavioral control which is a person's perception about their ability to perform the behavior (Jackson et al. 2005; Lavin and Groarke 2005, Corcoran 2007).

Health communicators in line with this theory identify potential barriers to the target audience's compliance with a stipulated health promoting behaviour and propose ways to eliminate the barriers. Such barriers may include the lack of skills needed to adopt the behavior.

Social Cognitive Theory: This theory proposed by Albert Bandura suggests that learning results from socialization. Human beings learn a behavior through observation of their social environment where others act. As the individual observes others, they recall past experiences with the kind of outcome associated with the behavior and use their recollections to determine their future behavior. Social interactions, past experiences, and the media are the significant factors in the individual's behavioral development (Concoran, 2007). Health communicators have borrowed from the social cognitive theory by using media models to promote desired health behaviors.

Another theory largely utilized in health communication is social marketing theory which incorporates "The Four 'P's of Marketing," to promote products that may be tangible or intangible. Health service provision is viewed as consumer service .The "Four P's of Marketing" are:

i. Product-which represents the behavior being promoted the associated benefits, tangible objects, and services that support behavior change.
ii. Price is financial, emotional, psychological, or time-related cost of overcoming the barriers the target audience faces in actualizing the desired behavior change.
iii. Place is where the desired behavior change will be performed or where they will access the program products
iv. Promotion is the sum total of the strategy with components like communication messages, materials, channels, and activities employed in reaching the audience.
v. A fifth 'P' which is policy support for health communication may be added to facilitate adherence (Bajracharya, 2018).

Health Communication Models

Social and Behavioral Change Communication, previously known as behavior change communication (BCC), develops communication strategies to achieve changes in knowledge, attitudes, norms, and beliefs in order promote positive health behaviors. Messages and activities across a variety of channels are used to target the individual, the community, services and policy.

The guiding principles of BCC assert that:

- BCC should be integrated with the goal and objective of the program
- Formative BCC assessments must be carried out while developing BCC messages
- Target population must participate during BCC development
- Key and direct stakeholders need to be involved from the design stage of BCC
- Pre-testing must be done for effective BCC materials
- BCC programs must involve planning for monitoring and evaluation.
- BCC strategies must be positive and action oriented (FHI 2002).

The Transtheoretical Model (also called the Stages of Change Model), developed by Prochaska and DiClemente in the late 1970s identified 6 stages in the process of making the decision to change and adopt a new behavior.

The first stage is the precontemplation stage when people do not consider their behavior as being problematic. At this stage people consider more the disadvantages of changing their behavior and do not see themselves changing in the near future.

The second stage is preparation where there is determination to change and people are ready to take action within the next 30 days. Actions are been taken towards the change. The third stage is called the action stage when people have recently changed their behavior within the last 6 months and they have the mind to keep moving forward with that behavior change. People may exhibit this by modifying their problem behavior or acquiring new healthy behaviors. The fourth stage is maintenance when people have sustained their behavior change for at least 6 months and intend to continue in that mode and work hard to prevent a relapse to the old behavior. The fifth stage is called termination when people have no desire to return to their old behavior. This stage is rarely reached, so many stay in the maintenance stage (SPH:2019).

The Transtheoretical Model has been criticized for different reasons; it wrongly assumes that people make well defined and logical plans in their decision-making process; it doesn't adequately take into consideration the social context in which change occurs which sometimes may call for drastic behavior modification; it has no well-defined criteria for determining an individual's stage of change; and it is unclear how much time is needed for each stage of change. In spite of its limitations, the model serves as a guide to health behavior change communicators in helping their target individuals and communities to attain the desired change (SPH, 2019).

Required Competencies in Health Education/Communication

Health management organizations or bodies have often outlined competencies that are required in health education in order to avoid miscommunication, miscomprehension, and misgiving.

According to CDC the health communicator must possess competencies in appropriate language choice, cultural responsiveness, racial sensitivity, gender sensitivity, inclusiveness for the disabled and a general understanding of the totality of the target audience's background.

With relation to the use of language, the CDC proposes avoidance of vague adjectives like vulnerable, marginalized and high risk that may suggest the health conditions are inherent in a group rather than in the factors that cause the condition. It is suggested that languages that focus on the effect of systems in place should be preferred like 'groups that are underserved with resources'. Language must not be stereotypical or dehumanizing. People must be described as having a condition and not as being the condition, for instance, persons with obesity is preferred to the obese. To enhance comprehension, message content should be translated into the preferred language of the intended audience, and a native speaker should review to ensure accuracy (CDC, 2021)

Cultural Sensitivity is another important competency in health communication. Messages and images used for illustrations must be pre-tested with people from a culture to ensure cultural appropriateness. Images used to illustrate medical conditions must also show, racial, cultural and gender sensitivity while consideration must be given to the ability of target audience to understand message content. Different audiences have varied ability to understand communication content according to their level of education, mental and physical ability and experience with health subject. Age must also be taken into consideration as the risk for diseases increases with age while the signs and symptoms of many diseases may be delayed or lessened in older adults. (Maibach et al 1994, CDC 2021)

METHODOLOGY

The cases of gender-blind and culture insensitive health communication in 8 top online health information sites were analyzed. Elements of health communication surveyed include: number of languages in which health message was interpreted; gender distinction in disease presentation for gender- discriminating diseases; racial distinctions in diseases that present differently for people of different racial descent; and racial balance in pictorial illustrations of disease conditions.

FINDINGS

Findings from this study showed that 4 out of 8 sites had content only in English Language; 2 had content in 2 different languages; 1 had content in 4 languages, and 1 in 5 Languages

These sites made no gender distinction in the description of some diseases known to manifest differently by gender such as sexually transmitted infections and some of the sites made no racial distinction in the description of some diseases such as asthma and diabetes with different prevalence and fatality rates for people of different racial descents. All the sites used white people to illustrate disease conditions, including skin conditions whose coloration would differ for different skin colors.

Discussion

The online medical information sites are visited by individuals seeking information to help them understand health conditions confronting them or the significant others in their lives. There is a need to make information sensitive to diverse racial, cultural, gender and individual groups.

Blindness to these diversities would only result in failure to meet health information needs of the target audience.

Conclusion

Many of these sites are offering free services to populations across the globe; while these services are highly beneficial, some areas can still be revisited for improved performance. Future studies may observe the impact that underrepresentation of race, gender, and cultural diversity has on the receipt of health information being communicated by these sites.

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Appendix

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https://medlineplus.gov/

https://www.medicinenet.com/

https://www.webmd.com/

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