APPEALING TO DIVERSE AUDIENCES: REACHING THE AFRICAN-AMERICAN COMMUNITY

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I am delighted to have been invited to participate in this exciting conference. This panel's topic—communicating health to diverse populations—is extremely important and I have been asked to speak on this topic in terms of the African-American community. First of all, it is important to keep in mind that there is no such thing as "the African-American community." As with all populations of color in this country, African Americans are a diverse, heterogeneous population. Therefore, when we think of how best to communicate science and health information to the African-American community, we will need to use many media, in numerous variations, for the messages to be perceived. Some communication strategies will work with most African Americans; some strategies will work with specific target segments of this population, such as adolescent boys, and will not work with other segments; some strategies may not work at all. Similarly, as we talk about the information superhighway and the Internet and Mosaic, we wonder if these are, or will be, elitist and inaccessible to the underserved.

Be assured that all the communication strategies that will be discussed during this conference are appropriate for a large segment of the African-American community. I predict that patterns of use will be similar between African Americans and European Americans; however, the difference will be in the proportions of the community using the varied media. We have heard the need for low-tech as well as high-tech avenues for the information from NIH that is communicated to Americans.

We all are aware that a people's health practices relate to their cultural views and their cultural beliefs and that there are segments of the African-American community with views and practices that differ from mainstream America. These often are the African Americans who are underserved and this is the African-American community on whom I will focus.

Before I present communication strategies, I would like to present only a few of the differences in cultural view that I feel serve as barriers to communication between the health world and underserved African Americans.[1,2] I will discuss these barriers briefly because my time is limited. These cultural views are held by a number of ethnolinguistically diverse populations; they are not exclusive to the African-American population.

The major barrier to communication is differences in the ways messages are perceived. Because the health and disease prevention messages that we want to reach African-American communities come from the health and medical fields, the messages are going to be viewed in a manner that is similar to how the source of the message is viewed. Thus, if the health and medical care system is perceived differently by underserved African Americans, so will the prevention messages that come from the health, science, and medical fields.

One cultural value of traditional mainstream American culture is that of personal control over one's environment, whereas many African Americans hold a view that can be referred to as fatalistic. Related to the idea of personal control over the environment is the concept of self-help. A self-help or personal control over the environment cultural belief will propel one to access a communication system, to seek information about health matters, and to change one's behavior. An individual holding a fatalistic cultural view may enter the process less assertively and may not be as likely to address prevention.

Another cultural contrast is a future orientation

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versus a past or present orientation. Prevention naturally has a future orientation, which matches the cultural view of a large segment of the population, the segment that takes advantage of the NIH telephone lines, pamphlets about health issues, and health and medical exhibits. In contrast, an orientation to today or the past may cause one not to forge assertively into a health science arena and learn about prevention or to independently seek treatment.

Another important variable is the "trust" factor that was often referred to yesterday. One speaker stated that a positive communication variable for NIH is that it has the public trust. For many African Americans, NIH does not have as high a trust value. There is of course the anxiety and anger discussed yesterday about conflicting information and confusion about health and science findings, but there is also suspicion. Suspicion about experimentation. Suspicion about intent. And suspicion, of course, reduces trust.

One successful model for communicating health information to African-American communities that I would like to refer you to is the community-based model developed for the National Heart, Lung, and Blood Institute by Anrow Sciences (now R.O.W. Sciences Inc). This model focused on high blood pressure and high blood cholesterol and had as its objective preventing or reducing cardiovascular and pulmonary diseases.[3]

An essential strategy for communicating health and science messages to African Americans is to use a community-based approach, for several reasons. A community-based approach reduces the suspicion that many African-American families have of government agencies, which is based on the negative experiences that they have had with government. Another reason a community-based approach is needed is that communication channels vary from community to community and cannot be predicted by those from outside the community.[3] For example, in Washington, DC, health information from Howard University, from Howard University Hospital, or from the University of the District of Columbia may be more positively received by underserved African Americans than a message from NIH. In my hometown of Durham, North Carolina, a message about children's health would be more positively received from Dr Cleland, a pediatrician who provided care to generations of African-American children, than from NIH.

The health communication program must begin with identification and long-term involvement of community members who know the needs, practices, and concerns of the community. These individuals know the literacy and educational levels of the target populations, their health practices, and their beliefs and they need to have the lead in organizing and planning the communication. Furthermore, I would certainly involve African-American advertising agencies in developing information for African-American communities.

Now, the message. I believe that the health messages more readily accepted by the underserved are not necessarily prevention messages—African-American adults are often more treatment-oriented, not heavily prevention-oriented. One approach that I believe can lead to increased motivation to adopt a prevention focus is to capitalize on the concept of the family.[3] All parents want their children to be healthy and not to experience disease or disability. Thus, while many adults may not seem very interested in preventing adult disorders, they will be interested in learning about health and prevention for their children. The temporal focus for many African-American parents may be the present for themselves, but they certainly have a future orientation for their children. An example of channeling prevention information to African-American adults is, at a family reunion, for the relatives to do a minigenealogy study to identify relatives who have or have had high blood pressure, heart disease, etc.[3] To get a message to older African Americans, for example, the message could be directed to the adult children of older parents; to get a message to men, the message could be directed to their wives and children, ie, to those who would be interested in the health of their husbands and fathers.

Thus, health information can be infused throughout an African-American community by 1) working with community persons to learn about the concerns, practices, and needs of the community and 2) developing and disseminating information using the family approach.

All communication media should be considered: public service announcements in different languages, videotapes, broadcasts on stations with listeners in the community, talk shows, and pamphlets that are attractive and richly illustrated. Recently, the *Washington Post* published an article stating that the top 10 television shows watched by African Americans are not the same top 10 shows watched by the rest of the country. Consequently, among African Americans, "Seinfeld" and "Home Improvement" are not watched as much as "Living Single," "Martin," and in their day, "In Living Color," and "Roc." Therefore, commercials targeted for African Americans must be aired during the programs most watched by African Americans.

I recognize that we are to consider the next millennium as we discuss communication strategies, and we have been talking about the information superhighway, the Internet, network and cable TV, and print media. However, during the past millennium, the current millennium, and I predict into the next millennium, the best education, information, and dissemination channel is person-to-person communication. African Americans should visit the institutions of the target communities and talk with the residents about the illnesses and treatments they have experienced. Person-to-person communication should occur in small group settings such as PTA meetings, club meetings, church group meetings, and sorority and fraternity meetings. This is truly interactive communication. Effective interactive communication takes place in churches, barbershops, beauty parlors, community centers, etc.

There is a long-term strategy that I believe will significantly increase the acceptance of prevention and treatment communication by the underserved. I began my talk by linking health and prevention communication to experiences with the health-care system. Unfortunately, for too many African Americans, experiences with medical care have often been frustrating because of the bureaucratic maze, the expense of services, and inappropriate treatment avenues. We all know the research indicating that African Americans often do not seek out medical services until a disease is advanced. We know that the poor often do not experience the same quality of care as those of us who can afford private medical care. Middle-class Americans receive most acute care in their physician's office; many of the poor receive acute care in outpatient departments and emergency rooms of hospitals, where the quality of care often is not the same. Since the African American's health-care experience is often not a very good one, why spend time reading information from an agent of this frustrating system? If health care can become more positive, then messages from the health and medical fields will be heard and respected.

African Americans are a diverse population. Communication strategies that work for the mainstream will work with the African-American community. However, communication strategies that work best with underserved African Americans are those that:

1. Use community-based information systems.
2. Involve community people in identifying the health and medical information that needs to be communicated and in planning the messages. Use an African-American public relations firm.
3. Relate communication about prevention and treatment to the family.
4. Disseminate information using all the media channels possible, not overlooking the effectiveness of interpersonal communication.
5. Disseminate information to the community institutions and individuals of trust.

African Americans are people- versus object-oriented. Many will receive the message better when it is delivered in person. While a brochure telling of the risks of smoking can be easily ignored, interacting with a stroke patient or visiting a Lost Chord Club will never be forgotten.

Literature Cited

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