Core Competencies for Adolescent Sexual & Reproductive Health

September, 2008
Core Competencies Subcommittee of the
California Adolescent Sexual
Health Work Group (ASHWG)

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The Core Competencies report was developed by the Core Competencies Subcommittee of the California Adolescent Sexual Health Working Group, an association of public and private-sector professionals with a shared interest in developing the capabilities of adult providers of adolescent sexual and reproductive health services. The members of the Subcommittee are listed at the end of the report. The views expressed in the Core Competencies report do not necessarily represent the official position of the institutions that the members of ASHWG or the Subcommittee are affiliated with, or the institutions that provided financial support for the development of the report. The Core Competencies report is available to the public in a downloadable format at the California Adolescent Health Collaborative website: http://www.californiateenhealth.org/CC_registration.php

The California Adolescent Health Collaborative is a statewide coalition of representatives from public and private agencies committed to a comprehensive, asset-based, multidisciplinary approach to improving the health and well-being of California youth.

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Overview

The Core Competencies herein are specifically intended for adult providers and educators of adolescent sexual and reproductive health, and represent the foundation of professional capabilities that all providers should strive to possess in order to deliver effective, sensitive, and appropriate sexual and reproductive health programs and services to adolescents.

It is our hope that every provider of adolescent sexual and reproductive health programs/services will possess, or strive to possess, at least a minimum degree of proficiency in each of the Core Competencies.

Programs and agencies might use the Core Competencies to:

- guide the hiring, training, development, and evaluation of staff,
- increase collaboration and cross training between agencies,
- support consistent health outcomes for adolescents,
- ensure that all programs are grounded in a shared body of knowledge and skills.

A variety of agencies and programs address the sexual health needs of adolescents in California. Programs may target sex education, pregnancy prevention, prenatal care, sexually transmitted infections (STI[1]), and HIV prevention, or relational issues. The staff and professionals who interact with youth include health clinic workers, test counselors, classroom teachers, case managers, clinicians, community educators, and health outreach workers, to name a few.

To best meet the sexual health needs of adolescents who may be involved in two or more different categorical program/services, a coordinated approach based upon commonly-shared knowledge and skills must be undertaken. Additionally, a solid foundation in adolescent development, human sexuality, and youth-centered approaches will help ensure that educational and prevention efforts are appropriate, consistent, and mutually supportive.

The Core Competencies are not meant to satisfy the entire skill set necessary for specific roles or jobs within the different fields or disciplines involved in adolescent sexual and reproductive health. For example, staff working in a particular discipline (i.e., HIV, STI, or contraception), will require special knowledge and skills over and above those included in this document. However, the Core Competencies do outline an essential set of knowledge and skills that all adolescent providers, regardless of discipline or specialty area, need to know about adolescent sexuality, pregnancy/contraception, HIV, and STIs so that interactions with teens are effective and consistent, and appropriate referrals can be made. As such, the Core Competencies are intended to be *mutually inclusive*, that is for example; the Professional and Legal domain applies to all other sections, and vice versa.

The Core Competencies are not intended as requirements or mandates binding a program or an agency to particular standards. They do not represent a curriculum or outline of topics/issues to be taught to adolescents. Rather they are intended as an interdisciplinary guide for providers to be used across various programs and service settings to enhance the level of service delivery and to improve continuity and consistency.

[1] The acronym STI is used for the sake of consistency and convention within this document, and does not reflect a preference over use of the more traditional acronym, STD. For more information about the use STI and STD, go to http://www.ashastd.org/learn/learn_statistics_vs.cfm

Related Efforts

ASHWG's *Core Competencies For Adolescent Sexual and Reproductive Health* are consistent with and supportive of the Program Collaboration and Service Integration (PCSI) initiative launched recently by Dr. Kevin Fenton, Director of the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention at the Centers for Disease Control and Prevention (CDC).

The success of PCSI depends on consistency and continuity of staff capability across different programs. Consistency and capability of staff across HIV, Hepatitis, STD, and TB programs can be achieved through the use of competency-based training and staff development activities – *because* the competencies will focus on **essential** knowledge and skill sets that must be shared among the staff from different programs – that is, *CORE* knowledge and skills.

This is part of the rationale for Dr. Fenton's PCSI Initiative as well as other national efforts that recognize the critical importance of developing competency-based training and curricula as a foundation for cross-training as a means to accomplish program collaboration and service integration. For more information on Dr. Fenton's PCSI initiative, go to www.cdc.gov/nchhstp.

Some of the other notable national efforts to define core competencies for public health staff include:

- **Council on Linkages between Academia and Public Health Practice**
  Core Competencies for Public Health Professionals www.phf.org/competencies.htm The Council on Linkages between Academia and Public Health Practice has worked hand-in-hand with CDC, National Association of County and City Health Officers (NACCHO), the American Public Health Association (APHA), and other national organizations to develop core competencies for public health professionals.
- **Competencies for Applied Epidemiologists in Governmental Public Health Agencies** Council of State and Territorial Epidemiologists www.cste.org/competencies.asp
- **QUAD Council Public Health Nursing Competencies**
  QUAD Council of Public Health Nursing Organizations, 4/3/2003
  www.astdn.org/publications.htm

The competencies developed by these organizations are profession-specific. ASHWG's **Core Competencies** are similar, but somewhat different in that they address several professions and job types involved in direct contact with adolescents in the delivery of adolescent sexual and reproductive health. Thus the competencies herein are focused on the knowledge and skill sets needed to appropriately address a *specific* health sphere (sexual and reproductive health) of a *specific* population group (adolescents). As such, the ASHWG Core Competencies identify the fundamental knowledge and skills sets shared by *different* professions and job types as a starting point for addressing adolescent sexual and reproductive health.

Examples of Differences

Between Core, Role, and Job-Specific Competencies For Providers of Sexual and Reproductive Health Programs and Services

The Core Competencies are intended to apply to all staff and professionals who interact with youth, including health clinic workers, test counselors, case managers, clinicians, classroom teachers, community educators, and health outreach workers, to name a few. As *core* competencies, they are intended to apply to staff below the level and specifications of a particular job or role (i.e., counselor, educator, clinician, etc.). Job-specific and role-specific competencies would be at a level above the core competencies and would vary by topic and organizational setting.

<table>
<tr><td>Job-Specific</td><td>Nurse:
For example, nurses in specified jobs such as a Family Planning NP or an RN in an HIV clinic.</td><td>Physician:
For example, doctors in specified jobs such as a doctor in an STI clinic or a doctor providing family planning services.</td><td>Counselor:
For example, counselors in specific jobs such as an HIV counselor,
a STI counselor, or a contraceptive counselor.</td><td>Health Educator:
For example, health educators in specific jobs or agencies, such as a CBO educator or a health department health educator.</td><td>Teacher:
For example, public school teachers who teach certain grade levels or certain subject areas, such as a high school health teacher or a middle school science teacher.</td></tr>
<tr><td>Role-Specific</td><td colspan="2">Clinician:
Common to all clinicians in STI, HIV, and Family Planning clinics, but different from counselors and educators</td><td colspan="2">Counselor:
Common to all counselors (HIV, STI, Contraceptive, etc), but different from clinicians and educators.</td><td>Educator/ Teacher
Common to all Educators/ Teachers, but distinct from counselors and clinicians.</td></tr>
<tr><td>*Core*</td><td colspan="5">The fundamental set of knowledge, skills, abilities, and perspectives that are basic to all providers who interface with adolescents on matters of sexual and reproductive health.</td></tr>
</table>

Application

The Core Competencies can be adapted and used by administrators, managers, trainers, and supervisors across various programs of adolescent sexual and reproductive health in several ways:

Recruiting and Hiring Staff: The Core Competencies can be used to write job descriptions, target the recruitment of applicants, guide the development of interview questions, and help to determine the suitability and skill level of potential applicants.

Self Assessment: Adolescent sexual health providers can adapt the competencies to measure personal and professional growth. Creating a scoring rubric allows the educator to use the competencies to measure progress in a wide range of skills and set goals for increasing knowledge and skill level.

Staff Development and Training: When designing professional development, the Core Competencies can serve as a needs assessment to determine the most important or needed knowledge and skills to be targeted for orientations, in-services, or training. Based on assessment results, they can guide the development of training objectives and activities, and be used to evaluate the effectiveness of training or staff development activities.

Performance Appraisal: Supervisors can apply a scoring rubric to the list of competencies so that staff self-assessment can be compared with the supervisor's evaluation of performance. This will allow the supervisor to set performance goals, monitor the progress of staff, and/or to develop work plans for areas needing improvement.

Inter-Program Collaboration: The competencies can facilitate coordination and collaboration between programs by prioritizing the knowledge and skills necessary for effective implementation and by ensuring quality and consistency within similar job functions across programs and disciplines.

Guiding Principles and Assumptions

The Core Competencies Subcommittee of the Adolescent Sexual Health Work Group (ASHWG) agreed on the following principles and assumptions in creating this document:

1. All people deserve to be treated with dignity and respect.
2. Sexuality is a critical dimension of adolescent development.
3. Sexuality and sexual behavior are defined and shaped by genetics, culture, tradition, race/ethnicity, societal expectations, socio-economic environment, spirituality, and religion.
4. Healthy sexuality is more than reproductive health or the avoidance of HIV, STIs, and unintended pregnancy.
5. Sexual relationships should never be coercive or exploitative.

The Core Competencies are divided into five major domains:

A. Professional and Legal Role
B. Adolescent Development
C. Youth-centered Approach and Youth Culture
D. Sexual and Reproductive Health
E. Pregnancy – STIs – HIV

Each major domain may be further categorized into two sub-domains regarding:

1. Cognitive sub-domain, what a provider should know
2. Operative sub-domain, what a provider should be able to do

A: Professional and Legal Role

Effective providers and educators have appropriate personal and professional boundaries when speaking to adolescents about sexuality. Awareness of personal boundaries requires an examination and understanding of personal beliefs, values, feelings and biases. Professional boundaries include knowledge of the legal and ethical considerations that guide interactions with youth. The maintenance of personal and professional boundaries is essential to avoid exerting undue influence on the developing adolescent.

The adolescent sexual health educator/provider:

A:1	Demonstrates a desire to work with young people.	OPERATIVE SUB-DOMAIN
A:2	Identifies and continues to clarify his/her own personal values, beliefs, biases, stereotypes, and feelings related to sexuality, and specifically adolescent sexuality.	
A:3	Conducts interactions with youth without emphasizing personal information and history, attitudes, values, beliefs, feelings, or religion.	
A:4	Takes a non-judgmental approach when dealing with attitudes, behaviors, beliefs, or cultures at variance with his/her personal beliefs or convictions – especially as they relate to adolescents and adolescent sexuality.	
A:5	Demonstrates confidence and comfort when discussing topics related to adolescent sexuality.	
A:6	Complies with the specific legal rights for California adolescents obtaining sexual and reproductive health services (i.e., birth control, STI treatment, HIV testing, etc.), such as confidentiality, minor consent to services without parental notification, access to care and treatment, and the safe surrender law.	
A:7	Adheres to the provider's legal and ethical responsibilities regarding adolescent sexual health, including: reporting coercive and/or abusive sex, disclosure, confidentiality, sexual responsibility, and the safe surrender law.	
A:8	Complies with the job-specific professional limits and expectations as a provider of sexual or reproductive health services to adolescents.	
A:9	Adheres to the policies and procedures of the employing organization, program, local community, and law enforcement.	
A:10	Demonstrates openness to receiving feedback from clients, colleagues, mentors and supervisors.	
A:11	Collaborates with colleagues and agencies in the delivery of adolescent sexual and reproductive health programs and services.	

B: Adolescent Development

Sexual and reproductive health education is grounded in an understanding of adolescent development. Sexuality is an integral part of the adolescent's cognitive, psychological, social, emotional and physical development and should be understood within this larger context.

The adolescent sexual health educator/provider:

B:1	Summarizes the cognitive, psychological, social, emotional, and physical dimensions of adolescent sexual development.	COGNITIVE SUB-DOMAIN
B:2	Summarizes the key theories/models of behavior change as they apply to adolescents.	
B:3	Describes the importance of gender, gender identity, sexual orientation, and gender expression in the development of sexual identity in youth.	
B:4	Explains how race, ethnicity, genetics, spirituality, religion, and culture influence the development of sexual identity.	
B:5	Explains how developmental stages, perception of time, and worldview are often different for adolescents than for adults.	
B:6	Explains the role of experimentation and risk-taking in the ongoing development of adolescence, including sexual behavior.	

B:7	Communicates that healthy sexuality is more than the avoidance of risk.	OPERATIVE SUB-DOMAIN
B:8	Explains how sexual health and decision-making can involve the interplay of knowledge attitudes, experiences, and context with various social determinants of health, (e.g. social and economic inequities, disempowerment etc.) and psychological state.	
B:9	Explains the boundaries, levels of intimacy, and dynamics of healthy adolescent relationships with peers and family.	
B:10	Identifies the indicators and/or warning signs of unhealthy adolescent risk-taking.	

C: Youth-Centered Approach and Youth Culture

The influence of peers and youth culture is critical to understanding the sexual behaviors and relationships of adolescents. The competencies in this section reflect current trends in youth development that emphasize respect for youth and approaches that identify and build upon the strength of each individual, while avoiding use of fear-based messages to motivate behavior.

The adolescent sexual health educator/provider:

C:1	Explains the contexts and factors that can influence sexual behaviors and relationships (e.g., pleasure, gender roles, socio-economic environment, power dynamics, sexual coercion, date rape, peer pressure, survival sex, alcohol/drugs).	COGNITIVE SUB-DOMAIN
C:2	Describes how technologies (e.g., cell phones, internet, text messaging) can impact on adolescent communication, relationships, dating patterns, bullying and harassment, sexual values and norms.	
C:3	Explains how the media's portrayal of sexuality can impact youth and youth culture.	

C:4	Treats all youth with respect and positive regard.	OPERATIVE SUB-DOMAIN
C:5	Adopts an asset/strength–based approach when interacting with youth, that is, the belief that all youth have strengths that can be built on.	
C:6	Applies the principles of resiliency, personal responsibility, and self-reliance to empower youth.	
C:7	Encourages young people to build connections to family and community and to find appropriate places/ways to get emotional support.	
C:8	Avoids the use of authoritarian, shame, and fear based tactics to motivate youth.	
C:9	Avoids the use of labels when discussing sexuality and sexual behaviors with youth.	

D: Sexual and Reproductive Health

These competencies outline a knowledge and skill set for the **provider** and are not necessarily taught to youth. The goals of sexual and reproductive health education go far beyond the prevention of infection or unintended pregnancy. Understanding the wide range of sexual and non-sexual relationships in which adolescents may be involved, will guide them toward healthy attitudes and behaviors. All communication with adolescents needs to be developmentally appropriate.

The adolescent sexual health educator/provider:

D:1	Summarizes the stages of sexual development over the life span: prenatal, infancy, early and middle childhood, adolescence, and adulthood.	COGNITIVE SUB-DOMAIN
D:2	Summarizes the anatomical, physiological, and psychological changes that take place during puberty.	
D:3	Describes the physiology and range of the human sexual response.	
D:4	Summarizes the psychosocial and environmental factors that impact sexual and reproductive health.	
D:5	Explains the concept of reproductive life planning, i.e. the importance of careful planning for intended pregnancy and parenthood and the importance of achieving good health during adolescence in order to ensure optimal reproductive potential in the future.	
D:6	Explains the meaning of gender; gender identity; gender presentation; sexual orientation; transgender, assigned sex, and intersex individuals.	
D:7	Summarizes the range of appropriate and inappropriate non-sexual and sexual relationships in which adolescents may be involved.	
D:8	Explains the impact and consequences of bullying, harassment, and abuse (sexual, physical, and emotional) on adolescent development and sexual and reproductive health.	

D:9	Emphasizes the importance of sexual and reproductive health care for adolescents with a focus on reproductive life planning.	OPERATIVE SUB-DOMAIN
D:10	Discusses sexual information and behaviors in a manner that is developmentally-appropriate using non-technical understandable language without labeling people and/or behaviors.	
D:11	Uses medically accurate* terminology related to the anatomy and physiology of sexual organs, sexual behaviors, pregnancy, sexually transmitted infections, and HIV, and clarifies unfamiliar terms used by adolescents.	
D:12	Explains how alcohol and other drug use/abuse can influence sexual decision-making and sexual behavior.	

***medically accurate** – means verified or supported by research conducted in compliance with scientific methods and published in peer-reviewed journals, where appropriate, and recognized as accurate and objective by professional organizations and agencies with expertise in the relevant field, such as the federal Centers for Disease Control and Prevention, the American Public Health Association, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists.

E: Pregnancy — STIs – HIV

The area-specific topics included here highlight the critical need for all providers and educators in adolescent sexual and reproductive health to have a basic understanding of the behaviors, risks, consequences, and prevention methods in these three topic areas. Providers specializing in one area would require more comprehensive knowledge and skill beyond what is highlighted here.

The adolescent sexual health educator/provider:

E:1	Explains the common behavioral factors often linking adolescent health issues; including unintended pregnancy, STIs, HIV infection, alcohol/drug use, and intimate partner violence.	COGNITIVE SUB-DOMAIN
E:2	Summarizes the fundamental facts of hormonal and barrier methods of contraception, including: mechanism of action, effectiveness, benefits/risks, how to obtain contraception and emergency contraception, and which methods do not provide protection against STI or HIV infection.	
E:3	Summarizes the fundamental facts on STIs, including: transmission, signs and symptoms, complications/consequences, the range of risk elimination (abstinence, Hepatitis A & B vaccines), and risk reduction options (condoms, HPV vaccines), the importance of STI testing if sexually active, and how STIs increase the risk for HIV transmission and infection.	
E:4	Summarizes the fundamental facts on HIV; including transmission, the spectrum of HIV disease and opportunistic infections, risk reduction, HIV testing options, and how HIV affects the immune system.	

E:5	Keeps updated on current, medically accurate* information on pregnancy prevention, STIs, and HIV, including local and state data on disease trends, through credible web sites, periodicals, journals, news reports, and workshops.	OPERATIVE SUB-DOMAIN
E:6	Explains the potential physical, emotional, economic, and social consequences of unintended pregnancy, STI infection, and HIV infection on adolescents.	
E:7	Discusses the current, medically accurate data on the effectiveness of condoms for reducing the chances of pregnancy and transmission of STIs and HIV.	
E:8	Discusses the importance of prenatal care and STI testing to sexually-experienced adolescents.	
E:9	Maintains familiarity with local community resources and accessible, teen-friendly health services for sexual and reproductive health.	
E:10	Provides information to teens on how to obtain sexual and reproductive health care.	

*** medically accurate** – see previous page

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The Contributions of Health Communication to Eliminating Health Disparities

The pressing need to eliminate health disparities calls on public health professionals to use every effective tool possible. Health communication, defined as the study and use of methods to inform and influence individual and community decisions that enhance health, was first recognized as a subset of the field of communication in 1975, when the Health Communication Division of the International Communication Association was founded.[1,2] The National Communication Association formed a division of the same name in 1985. In 1997, the Public Health Education and Health Promotion section within the American Public Health Association formally recognized health communication as part of its group. The peer-reviewed journal *Health Communication* began in 1989, followed 7 years later by the *Journal of Health Communication.* Today, while many communication departments and schools of public health offer limited graduate course work in health communication, there are fewer than a dozen comprehensive programs in health communication.

The federal government has recognized the contributions of health communication. The Centers for Disease Control and Prevention developed an office of communication in 1996 with the purpose of diffusing the science of health communication throughout the agency. The National Cancer Institute, in 1999, developed an "Extraordinary Opportunity in Cancer Communications," which included awarding Centers of Excellence in Cancer Communication to 4 universities; 2 of the 4 centers explicitly focus on research in health communication aimed at health disparities. In addition, for the first time, health communication is part of the Healthy People 2010 objectives.[3]

THE SCOPE AND LIMITATIONS OF HEALTH COMMUNICATION

These achievements not withstanding, the public health community seems to have a limited understanding of what health communication can offer to the elimination of health disparities. According to the National Cancer Institute, health communication can increase the intended audience's knowledge and awareness of a health issue, problem, or solution; influence perceptions, beliefs, and attitudes that may change social norms; prompt action; demonstrate or illustrate healthy skills; reinforce knowledge, attitudes, or behavior; show the benefit of behavior change; advocate a position on a health issue or policy; increase demand or support for health services; refute myths and misconceptions; and strengthen organizational relationships.[1(p3)]

However, health communication alone, without environmental supports, is not effective at sustaining behavior changes at the individual level. It may not be effective in communicating very complex messages, and it cannot compensate for lack of access to health care or healthy environments.[1(p3)] Nonetheless, we believe that public health professionals should use the full range of health communication strategies in the effort to eliminate health disparities.

THE RANGE OF HEALTH COMMUNICATION STRATEGIES

Many are familiar with mass media campaigns aimed at stimulating individual behavior change. However, there is less familiarity with other forms of health communication that can be effective in the context of health disparities. Health communicators can bring their expertise to bear in entertainment-education, media advocacy, new technology, and interpersonal communication, including patient–provider communication.

Entertainment-Education

Entertainment programming in the media is a powerful way

to communicate health information, especially for minority audiences, who are heavy consumers of this type of media. Several research studies have demonstrated that even brief exposure to health information and behaviors through entertainment media can have strong effects. In surveys (n=3719) conducted by Porter Novelli during 2001, more than half of regular prime time and daytime drama viewers reported that they learned something about a disease or how to prevent it from a TV show. Among minority viewers who watch regularly, 70% of Hispanic women, 65% of Black women, and 64% of Black men said they took some action after hearing about a health issue or disease on a TV show.[4] More than 50% of Black men and women reported that a storyline helped them to provide information to friends or family, as did 60% of Hispanic women.[4] Entertainment programming has the capacity to reach significant proportions of the populations experiencing health disparities.

Media Advocacy

Media advocacy is defined as the strategic use of mass media and their tools, in combination with community organizing, for the purpose of advancing healthy public policies.[5(p338)] Because the roots of health disparities extend to social, economic, and political conditions, media advocacy, which moves beyond the focus on the individual, holds promise as one form of health communication to address health disparities. One example of such a campaign is the Uptown Coalition in Philadelphia, which used the media and community organizing to defeat RJ Reynolds's proposed campaign to market Uptown cigarettes in African American communities.

Interactive Health Communication

Interactive technology, "computer-based media that enable users to access information and services of interest, control how the information is presented, and respond to information and messages in the mediated environment,"[6(p2)] has created new opportunities for health communication that can overcome barriers such as low literacy and expand opportunities to tailor and personalize information. One of the pioneer applications of such technology is the Comprehensive Health Enhancement Support System (CHESS), for which there is impressive research evidence of its potential for reducing disparities. In a study of the use of an HIV CHESS application, women and minorities made more use of several information tools than men and nonminorities, and minorities and those with less education used the decision and analysis tools more than nonminorities and people with more education, even though these tools were the most complex in the system.[7] Similar results were found in a pilot study of low-income, African American women with breast cancer.[7] Yet computer access issues prevent these approaches from achieving their potential in reducing health disparities.

Interpersonal Communication

Interpersonal communication theory helps us understand the provider–client interaction, the role of social support in health, and the ways in which interpersonal relationships influence health behaviors and decision-making. Clearly, the relationship between patient and provider can exacerbate health disparities. Van Ryn and Fu[8] suggest that providers may contribute to health disparities by influencing clients' views of themselves and their relation to the world, by differentially encouraging health promotion and disease prevention behaviors and services, and by withholding access to treatments or services and denying benefits and rights. They cite evidence of physicians' contributions to racial/ethnic disparities in kidney transplant rates and cardiac procedures, in pain assessment and control, and in mental health services. They argue for interventions to help providers avoid their own biases as one way to reduce disparities. Ashton and colleagues[9] examined communication between providers and minority patients and found that poor communication is linked to health disparities and requires specific interventions to address communication patterns.

Social support is another communication behavior that has profound consequences for mental and physical well-being.[10] Yet there is evidence that kinship support networks are deteriorating in low-income and minority communities because of unemployment, transience, and substance abuse.[11] Virtual support networks are becoming increasingly important, but again, access is an issue in underserved communities. Much more needs to be learned about the impact of culture on both expectations of support and the effects of support.

Cline's[12] argument for shifting the focus of interpersonal communication about health from formal to informal contexts such as everyday talk highlights a rich and untapped dimension of communication that could contribute to reducing disparities. Certainly, the impact of interpersonal communication through the use of lay health advisors, respected in their communities, is well documented. Extensive research on tailoring and targeting health messages promises new opportunities for reaching those who suffer most from health disparities.

CULTURAL DIFFERENCES AND HEALTH COMMUNICATION

However, in all these efforts, health communicators often struggle to understand the audiences they seek to reach, frequently equating culture in a simplistic fashion with race and ethnicity. The Institute of Medicine[13] argues that culture has been poorly examined in the context of health communication, asserting that to consider culture requires significant exploration beyond the typical variables of race, ethnicity, and socioeconomic status. According to the Institute, health communication campaigns typically address the issue of diverse audiences in 1 of 3 ways: by developing a communication campaign with common-denominator messages relevant to most audiences; by developing a unified campaign with systematic variations in messages to increase relevance for different audience segments, retaining one fundamental message; or by developing distinctly different messages or interventions for each audience segment.[13]

Many health communication interventions address what Resnicow and Braithwaite[14] refer to as the surface structure of a culture. Addressing surface structure includes matching

messages and channels to observable social and behavioral characteristics of a culture, for example, familiar people, foods, music, language, and places. It may be more important to address deep structure, which reflects the cultural, social, psychological, environmental, and historical factors that affect health for a minority community. Resnicow and Braithwaite argue that when health communication appropriately addresses surface structure, it increases receptivity to and acceptance of the campaign, but when it also addresses deep structure, it conveys true salience to the community it seeks to reach. Clearly, there is much to learn about creating health communication interventions that appreciate the complexity of culture, and then evaluating the impact of such programs on eliminating health disparities.

Eliminating health disparities requires that public health professionals expand their use of health communication strategies in comprehensive interventions aimed at effecting individual, community, organizational, and policy change. Such interventions can effectively address the multiple determinants of health that underlie disparities. However, to design effective interventions, we must understand the complexity of culture and integrate cultural factors into our health communication efforts. Furthermore, we must work collaboratively with communities experiencing disparities to overcome the historical context of distrust and create meaningful, effective health communication interventions. ■

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References

1. *Making Health Communication Programs Work.* Bethesda, Md: National Cancer Institute; 2001.

2. Freimuth V, Cole G, Kirby S. Issues in evaluating mass media health communication campaigns. In: Rootman I, Goodstadt M, Brian Hyndman, et al., eds. *Evaluation in Health Promotion: Principles and Perspectives.* Copenhagen, Denmark: WHO Regional Office for Europe; 2001:475–492.

3. *Healthy People 2010: Understanding and Improving Health.* Washington, DC: US Dept of Health and Human Services, Office of Disease Prevention and Health Promotion; 2000.

4. Office of Communication, Centers for Disease Control and Prevention. Entertainment Education: Overview. Available at http://www.cdc.gov/communication/surveys/surv2001.htm. Accessed July 21, 2004.

5. Institute of Medicine. *The Future of the Public's Health in the 21st Century.* Washington, DC: National Academies Press, 2003.

6. Street RL Jr, Rimal RN. Health promotion and interactive technology: A conceptual foundation. In: Street RL Jr, Gold WR, Manning T, eds. *Health Promotion and Interactive Technology.* Mahwah, NJ: Lawrence Erlbaum Associates Inc; 1997:1–18.

7. Hawkins RP, Pingree S, Gustafson DH, et al. Aiding those facing health crises: the experience of the CHESS project. In: Street RL Jr, Gold WR, Manning T, eds. *Health Promotion and Interactive Technology.* Mahwah, NJ: Lawrence Erlbaum Associates Inc; 1997:79–102.

8. Van Ryn M, Fu S. Paved with good intentions: do public health and human service providers contribute to racial/ethnic disparities in health? *Am J Public Health.* 2003;93:248–255.

9. Ashton C, Haidet P, Paterniti D, et al. Racial and ethnic disparities in the use of health services: bias, preferences or poor communication? *J Gen Intern Med.* 2003;18:146–152.

10. Albrecht T, Goldsmith D. Social support, social networks, and health. In: Thompson T, Dorsey A, Miller K, Parrott R, eds. *Handbook of Health Communication.* Mahwah, NJ: Lawrence Erlbaum Associates Inc; 2003: 263–284.

11. Roschelle A. *No More Kin: Exploring Race, Class, and Gender in Family Networks.* Thousand Oaks, Calif: Sage Publications; 1997.

12. Cline R. Everyday interpersonal communication and health. In: Thompson T, Dorsey A, Miller K, Parrott R, eds. *Handbook of Health Communication.* Mahwah, NJ: Lawrence Erlbaum Associates Inc; 2003:285–318.

13. Institute of Medicine. *Speaking of Health: Assessing Health Communication Strategies for Diverse Populations.* Washington, DC: National Academies Press; 2002.

14. Resnicow K, Braithwaite R. Cultural sensitivity in public health. In Braithwaite R, Taylor S, eds. *Health Issues in the Black Community.* 2nd ed. San Francisco, Calif: Jossey-Bass; 2001: 516–542.