Is There a Hard-To-Reach Audience?

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Synopsis ....

The "hard-to-reach" label has been applied to many different audiences. Persons who have a low socioeconomic status (SES), members of ethnic minorities, and persons who have a low level of literacy often are tagged as "hard-to-reach." The authors identify reasons why these groups have been labelled "hard-to-reach," discuss preconceptions associated with the "hard-to-reach" label, propose alternative conceptualizations of these audiences, and present implications of such conceptualizations for health communication campaigns.

Pejorative labels and preconceptions about various groups may lead to depicting these audiences as powerless, apathetic, and isolated. The authors discuss alternative conceptualizations, which highlight the strengths of different audience segments and encourage innovative approaches to the communication process.

These alternative conceptualizations emphasize interactive communication, a view of society in which individuals are seen as members of equivalent—albeit different—cultures, and a shift of responsibility for health problems from individuals to social systems. Recommendations for incorporating these alternative concepts into health campaigns include formative research techniques that create a dialogue among participants, more sophisticated segmentation techniques to capture audience diversity, and new roles for mass media that are more interactive and responsive to individual needs.

HEALTH COMMUNICATION campaigns often are mandated to reach those people who have the highest risks of mortality and morbidity from disease. Many of these efforts have been unsuccessful, leading health communicators to label certain segments of the audience as "hard-to-reach." This label has been applied to audience segments based on their socioeconomic status (SES), their ethnicity, or their level of literacy. In this article, we will critically examine the "hard-to-reach" label, look at some of the preconceptions associated with this label, and discuss alternative conceptualizations of these audiences that may be more useful for health campaigns.

"Hard-to-Reach" and Other Labels

Many labels have been attached to so-called "hard-to-reach" audiences, most of them pejorative. A sketch by Jules Feiffer illustrates the confusing and ever changing array of labels assigned to one of the audiences often labeled "hard-to-reach"—the poor. The cartoon shows a decrepit old man saying (1):

I used to think I was poor. Then they told me I wasn't poor, I was needy. Then they told me it was self-defeating to think of myself as needy, I was deprived. Then they told me deprived was a bad image, I was underprivileged. Then they told me underprivileged was overused, I was disadvantaged.

In the final panel the old man says, "I still don't have a dime."

"Hard-to-reach" audiences have been called obstinate (2), recalcitrant (3), chronically uninformed (4), disadvantaged (5), have-nots (6), illiterate (7), malfunctional (8), and information poor (5). These labels reflect communicators' frustration in trying to reach people unlike themselves and the failure of many campaigns to change high-risk behaviors.

In this article, we will focus on three audience segments often labelled "hard-to-reach": persons of low SES, members of certain ethnic minorities, and persons with low levels of literacy. We will define SES, ethnicity, and literacy; estimate the number of persons in each "hard-to-reach" group; discuss the impact of low SES, ethnicity, and low literacy on health status; and suggest why these segments have been labelled "hard-to-reach."

Low socioeconomic status. SES may be defined as a composite measure incorporating income, education,

and occupation. In quantitative studies, however, education or income is frequently used as the sole indicator of SES. According to Mechanic (9), SES identifies a person's location in the social strata and consequently his or her access to material goods, information, and power.

The Bureau of the Census publishes the numbers of persons with low SES as measured by income. In 1987, more than 32 million Americans—21.4 million whites, 9.7 million blacks, and 1.4 million of other races—lived below the poverty line, set at $11,611 per year for a family of four persons (10).

Research has consistently indicated that persons in the lowest SES stratum have the highest risk of death and disease (11). Numerous studies of the relationship between SES and health conclude that poor health, inappropriate health behavior, low levels of health knowledge, and little use of preventive health services cluster significantly in the lowest socioeconomic groups (9, 12).

The literature in this area suggests several explanations for the impact of SES on health: persons in the low strata may have fewer financial and psychological resources to respond to health problems; they may suffer from increased exposure to environmental hazards; they may exhibit low self-esteem and unwillingness to delay gratification, which may adversely affect health; and they may practice less healthful behaviors (13).

Such explanations create a sense of low SES populations as "hard-to-reach." Those below the poverty line often are depicted as both financially and psychologically impoverished, focused on short-term rewards, and therefore uninterested in pursuing preventive behaviors. These people are labelled as less responsive to suggested health behavior change because they are said to care less about themselves than higher status persons and have less health knowledge to build on. Finally, they may be labelled "hard-to-reach" because they have not adopted behavior change strategies at the same rate as their middle and upper class counterparts.

Ethnicity. Ethnic groups are composed of persons who share a unique cultural and social heritage passed from one generation to another (14). Ethnicity is not synonymous with race. Race refers to a system of classifying humans into subgroups based on specific physical and structural characteristics (14). Since the "hard-to-reach" label has been most frequently applied to black and Hispanic ethnic groups, we are limiting our discussion to these two ethnic groups.

According to the 1989 Statistical Abstracts (10), one out of every five persons in the United States is a member of an ethnic minority. Blacks are the single largest ethnic minority, constituting 12.2 percent of the total

population or 29 million people. Hispanic Americans constitute 8.8 percent of the population, or about 19 million people, and are a rapidly growing ethnic minority.

The 1985 Report of the Secretary's Task Force on Black and Minority Health (15) clearly documented the detrimental effects of minority status on health. Life expectancy at birth for white males in 1982 was 71.5 years contrasted with 64.9 years for black males. Data were not available for Hispanic Americans. Another indication of the impact of minority status on health comes from the Centers for Disease Control AIDS data (10). Both blacks and Hispanics comprise small percentages of the total U.S. population, yet account for 29.5 and 13.6 percent, respectively, of all diagnosed cases of AIDS.

Planners of health programs trying to define their target audiences often experience difficulty separating ethnicity and SES, perhaps because minorities are overrepresented in the lower SES groups. While only 10.5 percent of all whites had incomes below the poverty level in 1987, 33.1 percent of all blacks and 28.2 percent of all Hispanic Americans fell into this low SES classification (10). Moreover, health data are reported by ethnicity more often than by income or education.

The blurring of distinctions between minority status and SES is exacerbated by sampling problems characteristic of much of the research on which health campaigns base their objectives and strategies (16). Frequently only the lowest socioeconomic stratum of the minority population is studied, rather than a representational cross-section. In large national probability samples, blacks are often oversampled by locating census blocks or telephone prefixes in primarily black urban ghetto areas (16). The result is frequently an overrepresentation of the lowest classes and an absence of middle and upper class blacks.

Blacks and Hispanics have been labelled "hard-to-reach" because their cultures are different from the mainstream culture and sometimes not well understood by many who plan health programs. Because of the history of racist treatment of these ethnic groups, communicators approach them cautiously, concerned about being offensive in attempts to adapt messages to these groups. In addition, English-speaking communicators may encounter difficulties with Hispanic audiences due to language differences.

Level of literacy. Literacy has been defined most simply "as the ability to read and to write one's name" (17). Hunter and Harmon define functional literacy as

... the possession of skills perceived as necessary by particular persons and groups to fulfill their

own self-determined objectives ... This includes the ability to obtain information they want and to use that information for their own and other's well being....

Estimates vary greatly, but somewhere between 21 to 60 million adult Americans are illiterate or only marginally literate (18, 19).

The research literature on the impact of illiteracy on health is sparse. One Canadian study lists a number of direct and indirect effects of illiteracy on health (7). The direct effects include incorrect use of medication, inability to comply with medical directions, and errors in administering infant formula. Indirect effects of illiteracy on health include higher-than-average rates of occupational accidents and lack of access to health information and services.

Health educators and communicators categorize this population as "hard-to-reach" because illiterate persons cannot read printed materials, the most widely available form of health information. In addition, some authors posit (20) that illiterate and marginally literate persons have underdeveloped information processing skills and are therefore confused by complex written and verbal medical instructions.

Preconceptions about the "Hard-to-Reach"

Numerous preconceptions have been associated with audiences labelled "hard-to-reach." Four common preconceptions about "hard-to-reach" audiences are that they are fatalistic, have poor information processing skills, have limited access to communication channels, and distrust dominant institutions. While these preconceptions may have a foundation in statistical data, they can perpetuate myths about groups that are discriminatory, fallacious, and patronizing. Our purpose is to describe the common preconceptions about "hard-to-reach" audiences found in the literature. In a later section of the paper, we will present alternative ways of viewing these audiences that we believe are more useful for health communicators than these preconceptions.

Fatalism. A prominent preconception about those labelled "hard-to-reach" is that they tend to be fatalistic (5), and that the accompanying pervasive sense of helplessness impacts negatively on their health status. The American Cancer Society's "Cancer and the Poor: A Report to the Nation" illustrated the relationship between fatalism and health status (21):

... based both on limited knowledge and the reality of their encounters with the healthcare system, poor Americans mistakenly believe that there is

no hope of surviving cancer. Fear and misconceptions about cancer prevent many poor Americans from seeking needed care.

Poor information processing skills. Another preconception about "hard-to-reach" audiences is that they may have a low level of reading skills, may speak English as a second language, and may not possess the basic communication skills needed for everyday transactions (5). Some researchers suggest that "hard-to-reach" audiences may lack well-developed cognitive skills and problem-solving orientations (9). Feldman (22) claims that those with less education are less well-informed, less exposed to new information, and tend to learn less when exposed. Other researchers assert that persons with poor communication skills tend to think in concrete rather than abstract terms and that their knowledge may be based on immediate experience (23).

Limited access to communication channels. Not only are information processing skills of "hard-to-reach" audiences underdeveloped, their information channels are limited. According to this preconception, most of the "hard-to-reach" groups report heavy use of television but much less use of print media. Childers and Post (5) identify the disadvantages of this overreliance on electronic media. They argue that persons labelled "hard-to-reach" are overexposed to "ends" information (messages that increase what one wants to achieve) through television and radio but underexposed to the kind of information largely available through print media that might help them achieve the desired ends.

The nature of the communication networks of "hard-to-reach" audiences is another part of the preconception about limited communication channels. These audiences are said to be locked into information ghettos where contact from the outside is limited. As a consequence, these sources argue, much misinformation is prevalent. As Childers and Post put it, "there is a kind of social embargo against a great body of externally generated information" (5).

Distrust of dominant institutions. Another preconception about those audiences labelled "hard-to-reach" is that they distrust dominant institutions, such as Federal, State, and local government agencies. McKnight, for example, argues that lack of knowledge and utilization of services by these audiences stems not from a lack of information but from a mistrust and even a deliberate rejection of the "establishment" position (24).

A review of the literature on Hispanics and cancer concluded that many low-income Hispanics distrust the community health care system and do not take advantage of the available services, apparently because of

their perception that government agencies exploit low-income people and that professionals are obstacles to receiving any meaningful help (25). Some low-income Hispanics have not used public sector health programs because they believe that government employees will collect information identifying illegal residents in their family (26).

The preconceptions we have presented of "hard-to-reach" audiences combine to create images of multiple-disadvantaged, uncooperative, and ultimately unreachable persons. The following is an example (12):

> The poor behave differently from the middle class and the affluent across a wide spectrum related to health care. Illness is defined differently. There is less accurate health information. The poor are less inclined to take preventive measures, and delay longer in seeking medical care. When they do approach health practitioners, they are more likely to select subprofessionals or the marginal practitioners often found in their neighborhoods.

Alternative Conceptualizations

While we acknowledge that the three audience segments discussed do suffer disproportionately higher rates of morbidity and mortality, we believe that the practice of negatively labelling and characterizing such groups has been counterproductive. This section presents alternative ways of viewing these audiences emphasizing strengths rather than weaknesses. In the 1970s, authors such as Ettema and Kline (27) recognized the consequences of focusing on deficits of groups and blaming them for their problems. Building on these ideas, Dervin (3) proposed an alternative conceptualization of the communication process that yields some important implications for reaching audiences.

Emphasizing differences rather than deficits. Ettema and Kline (27) described the difference versus the deficit thesis. The deficit thesis arose from research examining the achievement gap which assumed that the relationship between SES and intellectual performance was caused by a deficiency of basic cognitive ability. The composite picture of the "hard-to-reach" audience presented previously exemplifies this deficit perspective. The alternative conceptualization, the difference thesis, argues that people from different social strata have the same underlying competence as those in the mainstream of the dominant culture. An emphasis on deficits conveys a hopelessness about ever reaching those labelled "hard-to-reach." By contrast, the difference thesis suggests that when people are motivated to acquire information and that information is functional in their lives, they will make use of it (27).

One example of emphasizing differences rather than deficits may be found in the work of Fingeret who presents an alternative picture of the illiterate adult (8). According to a deficit perspective, illiterate adults are nonfunctional in our print-oriented society. However, the difference perspective suggests that illiterate adults participate in an alternative culture in which literacy is not as key as it is in the dominant culture. She recounts interviews with illiterate persons who describe a sophisticated barter system they use to trade their skills and knowledge for the reading and writing abilities of their neighbors (28). She argues that the mainstream society needs to credit the life experience and oral culture of the illiterate person.

Another example of replacing a deficit perspective with a difference perspective comes from Lyons's proposal to replace the term "disadvantaged" with the term "other advantaged" (1). He argues that "disadvantaged" implies a deficit in education, family, and future life possibilities, while "other-advantaged" suggests that each person experiences advantages and disadvantages in different aspects of his or her life. He advocates acknowledging the strengths of the poor and their contributions to society and themselves.

Blaming society rather than persons. Individual blame is the tendency to hold a person responsible for his or her problems, rather than the society of which a person is a part (6). Societal blame is the tendency to hold a social system responsible for the problems of individual members of the system. For example, an individual blame perspective would lead to efforts to get people to stop smoking while a system blame perspective might focus on the tobacco companies, advertisers, and legislators.

Even though a few innovative campaigns in smoking and alcohol abuse have included such system level strategies as banning smoking in public places, placing warning labels on products, and imbedding pro-health messages in entertainment programming, many health campaigns adopt a person-blame perspective. Seat belt campaigns try to persuade drivers to buckle up rather than pressuring car manufacturers to produce safer automobiles. Cancer campaigns focus on a person's dietary choices rather than going after the food manufacturers or the fast food outlets. Health communicators may focus on the person because they feel helpless to change the larger society. Additionally, traditional values in our society emphasize individual responsibility, assuming that it is the duty of each person to make appropriate lifestyle changes to reduce his or her risk of preventable disease. Blaming the social system places the responsibility for change on the entire system. The

nationalization of health care is an example of this approach.

Communication-as-dialogue. Dervin's ideas build on these earlier recommendations to emphasize differences rather than deficits and to eliminate person blame (*3*). She advocates a change in the conceptualization of information and communication. Dervin criticizes the assumptions underlying most information campaigns as following an information-as-description model and offers an alternative conceptualization, information-as-construction (*3*).

> The information-as-description model assumes that information has truth value, has a known, testable descriptive relationship with reality, and can be separated from observers. The information-as-construction model assumes that information is created by human observers, is inherently a product of human self-interest, and can never be separated from the observers who created it.

For example, the information that a woman would construct from a message urging her to get a mammogram would be affected by her previous experiences with mammograms, her fear of breast cancer, and her attitudes toward the source of the message.

Dervin suggests that the information-as-description model implies that communication is a linear process. A source—be it person or agency—assumed to have access to the truth has the responsibility to transmit that information to people who need it. She argues that, instead, communication must be conceptualized as both parties involved in creating information by establishing a dialogue.

More than 40 studies (*3*) have used Dervin's approach and have yielded the following conclusions that support her conceptualization of information and communication.

• People inform themselves primarily at moments of need.
• People rely first on their own cognitive responses. If these are not sufficient, they turn first to sources close to them or those contacted habitually.
• People judge information on how it helped them rather than on its expertise or credibility.

Implications for Health Campaigns

These alternative conceptualizations are very similar in their emphasis on the importance of involving the audience, respecting the unique strengths that the audience brings to the health communication process,

and redefining communication as an active exchange between participants. Adopting these alternative conceptualizations leads to important implications for various steps in the health communication process.

Different formative research techniques. After early failures of linear campaigns directed to passive audiences (*29*), communicators discovered that they had to learn about audience needs and solicit reactions to the materials under development. Hence, needs assessment research and pretesting of materials became commonplace. While formative research does involve the audience, it often places them in a reactive rather than a proactive role. For example, in most pretesting, audiences are asked for feedback on message concepts and strategies rather than being invited to help formulate the ideas. Many of the formative research techniques use close-ended questions in which the researcher defines the range of answers instead of open-ended questions in which members of the audience may frame their own responses. New formative research techniques are needed that create a dialogue among the participants.

Dervin's time-line interviews are one example of such a technique. Specifically, she recommends an interview in which the researcher asks the respondent to recall what happened in a situation as a series of steps—what happened first, second, and so on. For each step on the time-line, the researcher probes for how the respondent saw and defined the situation, its uncertainties or gaps, how those gaps were resolved, and resources that were useful in bridging those gaps. This approach suggests ways to understand how the members of the "hard-to-reach" audience make sense of their everyday lives, and how their behaviors are linked both to messages they attend to and the social structures of their lives. There are some other notable examples of these formative research techniques.

The American Cancer Society (ACS) held regional hearings around the United States in 1989 to gather testimony from the poor about their cancer experiences (*21*).

> Disadvantaged whites, blacks, Hispanics, American Indians, and older people described with passion their frustration in seeking and obtaining care, their battles with insensitive providers and with bureaucracies which create unnecessary obstacles to care.

Based on this testimony, new policy guidelines are being developed to make cancer information and treatment services to the poor more available, meaningful, and affordable. This program effort by ACS was an attempt to generate more effective and interactive communication between the poor and nonpoor.

Nitzke and coworkers' (30) use of the language experience approach, a method to teach reading using the students' own statements, to develop nutrition education materials for low-income women is another example of audience involvement. The text for these materials was developed from participants' statements about food and nutrition. In addition, the women were asked to comment on the final product and share the information with friends. Women who shared the information with friends showed improvement in knowledge, attitude, and behavior when compared with persons who did not share information. This process made the target population an integral part of the intervention, using their language, ideas, beliefs, and concerns to develop materials.

A final example of formative research in which the audience plays a pro-active role comes from an inner-city program to prevent acquired immunodeficiency syndrome (AIDS) that was developed from listening to and learning about the needs of the community (31). This AIDS prevention program focused on "strawberries and raspberries"—very young girls who sold sexual services for a few dollars to buy drugs. Some of these girls were hired by the AIDS program to work as AIDS educators to develop and distribute information to other "strawberries and raspberries."

More sophisticated segmentation techniques. As formative research becomes more of a dialogue, allowing greater insight into the audience's values and beliefs, we may discover that traditional approaches to segmentation are not adequate. Health campaigns have relied on demographics such as sex, age, ethnicity, and SES to divide the mass audience into more homogeneous subsets. Yet these demographically defined subsets may still be too broad and diffuse.

Another approach to segmentation, adapted from marketing, is psychographics, which uses the attitudes and lifestyles of audience members to develop target groups. Psychographics may offer a way to focus on differences rather than deficits of audiences that have been labelled "hard-to-reach."

For example, the National Cancer Institute (NCI) used psychographic segmentation to identify six distinct groups (32). One such group, the naive optimists, was described as generally optimistic, self-involved, and complacent about their health. They did not feel a need to worry about their health, seek health information, or make any effort to stay healthy. Naive optimists, according to this NCI report, make up about 12 percent of the population. They are young with higher incomes than the other segments.

Two advantages of this segmentation approach are apparent. First, this psychographic technique produces a more detailed and richer portrait of a group and yields many implications for message development and delivery. For example, the NCI psychographic study concluded that messages that convey immediate benefits would best motivate the naive optimists and that friends and relatives would be the most influential sources to reach this segment. Second, psychographic segmentation reveals differences in audiences that demographic segmentation might overlook. In the NCI study, the naive optimists are relatively similar demographically to one of the other six groups but contrast sharply with it on some attitudes toward cancer.

New roles for the mass media. Traditionally, health communication campaigns have included public service announcements (PSAs) on television and radio, print advertisements, posters, and pamphlets. These campaigns are characterized by a centralized source pre-packaging information and disseminating it in a linear manner to a set of passive receivers. Adoption of the communication-as-dialogue model necessitates a change in this process.

The Cancer Information Service, a national telephone information and referral service, is an example of a health information program more consistent with the alternative conceptualizations that have been discussed (33). The telephone links the caller and the information specialist in an interpersonal encounter, which is interactive, dynamic, and flexible enough to meet the self-identified needs of the person.

The Chemical People Project (34) offered another innovative role for the mass media that was consistent with Dervin's conceptualization of audiences. This project to combat school-age children's drug and alcohol abuse was developed by WQED, a public broadcasting station in Pittsburgh. The Chemical People model had two major components: media—both electronic and print—and outreach—grass-roots intervention and organization. Two nationally televised programs served as a catalyst to stimulate local community organization. Outreach was used to develop a task force in each community to provide a structure for the energies aroused by the television shows and to funnel those energies into positive action. These community groups then responded to their own local needs.

Conclusion

"Hard-to-reach" is a term that has been applied to numerous groups targeted by health communicators. The term has negative connotations for those targeted, suggesting that they are somehow more difficult to communicate with than other audiences. In this article, we have discussed labels applied to so-called "hard-to-

reach'' audiences, the preconceptions associated with these labels, some alternative ways of viewing the audience and the communication process, and the resulting implications for health communication campaigns.

Poverty, disadvantage, and disproportionate morbidity and mortality among certain groups are very real conditions in our society. Rather than emphasize these characteristics of groups, we have described several alternative conceptualizations that may suggest nontraditional approaches to be taken in health communication campaigns. We are not so much proposing radical change in the design of campaigns, but rather we hope to stimulate creative thinking about more sophisticated segmentation methods, innovative uses of mass media, and more positive conceptualizations of persons traditionally characterized by their ''lack of'' rather than their ''wealth of.''

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