

A Framework for Equity-Centered Health Communication



**communicate
health**

Foreword:

Why We Wrote This Now

The COVID-19 pandemic forced us to reckon with some hard truths. For the sake of brevity, we'll sum 3 of them up here:

- **Too often, our public health guidance doesn't reach people in a timely and effective manner.** This becomes especially problematic in an emerging pandemic, but clear communication is critical during non-emergencies, too.
- **Until we prioritize equity, our public health system will continue to benefit some people over others** — just like our education, justice, and political systems. These inequities are based on socially constructed factors like race, wealth, gender, sexuality, and ability. And crises like COVID-19 will continue to exacerbate the health disparities that exist because of these inequities.
- **Our entire approach to public health is based on people having a basic level of trust in public institutions.** Without it, our health communications are destined to fail.

In response to these hard truths, pretty much everyone — including leadership at the Centers for Disease Control and Prevention (CDC)¹ — is calling for more emphasis on health equity, transparency, and clear health communication. At CommunicateHealth, we're all for it.

But how does this work in practice? Unfortunately, guidance in this department is a bit thin, leaving many public health communicators with more questions than answers. What does centering equity in health communication *look* like? And how is it different than what we've been doing to date? What does clear, accessible public health guidance *sound* like?

We have some ideas.

At CommunicateHealth, we've been following an equity-centered health communication model for more than a decade. We started with the fundamentals of health communication, and over the years we added some adult learning theory, mashed it up with principles borrowed from human-centered design, and elevated one criterion for success above all others: Is the information easy to access, understand, and use? (If this string of verbs sounds familiar, it's because it makes up the core definition of personal health literacy.²)

The result is a health communication framework that prioritizes equitable access to basic health information and services. It's by no means groundbreaking or even original. But it's simple enough to follow, and we've used it to train hundreds of CommunicateHealth team members over the years.

Public health communication is at a crossroads. And we're optimistic that, together, we'll chart the right path forward. We hope, in some small way, this framework will help set us on that path — or at least get us asking the right questions. Fact is, health communication can worsen health inequities, or it can start to close gaps in access and understanding. And small shifts in our methods and mindsets can make all the difference.

The future of public health communication is ours to redesign.

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<https://communicatehealth.com/wp-content/uploads/ch-echc-framework.pdf>

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Introduction



As communicators, we know the words we use can have a powerful impact on the way people think, feel, and act. At best, our words can open minds and make people feel seen and heard. At worst, they can confuse, alienate, and shame. In our public health practice, it can be both accurate and empowering to name not only the groups of people we're talking about — but also the systems of oppression that have shaped the distribution of power and resources that affect them.

In short, language is a simple starting point for meaningful change. But it can't be the end point. To rebuild public trust and advance health equity, we must shift not only the words we use but also how we design and deliver health communications. And given the massive unintended consequences of poor communication and the growing threat of misinformation and disinformation, now is the time to revisit the best practices and assumptions underlying public health communication.

The fundamentals of the health communication process laid out in [Making Health Communication Programs Work \[PDF - 4.3 MB\]](#) (aka “the Pink Book”)³ — and in subsequent publications like [CDCynergy](#)⁴ — continue to guide the practice of health communication today. This is remarkable considering the Pink Book was first published in 1989 and last updated more than 20 years ago. And it’s a testament to the scholars and practitioners who built a strong foundation for the field — a foundation based on understanding the unique information needs of the audiences we serve.

In recent years, some organizations have applied more creative problem-solving methodologies — like design thinking and human-centered design — to public health challenges, finding this agile adaptation of the traditional “plan-implement-evaluate” model better suited for today’s increasingly diverse and digital world. (At CommunicateHealth, we follow a hybrid model described on page 12.)

The reality is that, in their current state, these communication frameworks and methodologies aren’t enough to counter legacy and present-day systems of health and human inequities. Full stop. And yet, we believe that even small shifts in how we practice health communication can go a long way toward rebuilding trust and disrupting the power imbalances at the root of health inequities. These shifts are as much about mindsets as they are about methods.

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In this framework, we attempt to describe some of these shifts — and the questions and considerations that come with them. We start by recognizing diversity of identity, perspective, and experience for what it is: a driver of better health communication.

For too long, people of color, LGBTQI+ (lesbian, gay, bisexual, transgender, queer, intersex) people, people who live in rural areas, disabled people, and others directly and disproportionately impacted by health inequities have been shut out of decision-making processes that directly impact their lives. If we're going to rebuild trust in public institutions (and ultimately in public health), we have to start by talking to people who are excluded from these institutions. We have to start talking about generational poverty and income inequality in this country. If we're going to reach young people, we have to talk less about finding and treating cancer early and more about protecting people — and the planet — from chemicals that cause cancer in the first place.



Start by recognizing diversity of identity, perspective, and experience for what it is: a driver of better health communication.



Practicing equity-centered health communication requires strategies to shift power, including who has power to identify the problems and the solutions to drive change. In practical application, this may look like co-creating communications with impacted community members. It may also mean reframing public health issues to explicitly name how structural, organizational, and interpersonal racism, ableism, and oppression have contributed to the problem. Lastly, equity-centered health communication requires that we continually build humility and practice empathy in our work.

What is health equity?

If there's one term you're hearing most in public health right now, it may well be "health equity." But the thing about terms everyone is using all the time in various contexts is that the meaning can get a little lost. So for clarity, we've included a definition from the Robert Wood Johnson Foundation: *Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.*⁵

Another way to think about it is this: Achieving health equity means that health status and outcomes won't be predictable based on a person's identities or characteristics — including race and ethnicity, gender and gender identity, sexual orientation, and many others. Imagine!

Toward an Equity-Centered Practice of Health Communication

Our ability to access, understand, and use health information is referred to as health literacy. At CommunicateHealth, instead of viewing health literacy as an individual trait (or deficit, really), we see it as a product of a poorly designed health care and public health system.

When a system is hard to navigate, chances are people will struggle to find their way. When people are feeling overwhelmed — like when they're sick or facing a new diagnosis (or a novel coronavirus) — navigating complex systems gets even harder. And because of systemic and structural racism and inequities, people of color, LGBTQI+ people, and people with disabilities face more obstacles to getting the health information and care they need.


Every public health communication product, campaign, or message we develop can either raise or lower barriers to access and understanding. We believe that it's our collective responsibility to lower these barriers to health.

That's why, at CommunicateHealth, we strive to create communications that are:


- **Clear.** We create materials that are easy to understand and use.
- **Relatable.** We develop resources that reflect the lived experiences of our audiences so people can see themselves in our communications.
- **Actionable.** We provide our audiences with information they can use to take care of their health and keep their families safe.
- **Inclusive.** We craft accessible resources that meet the needs of as many people as possible in as many circumstances as possible.

Of course, there are plenty of other important factors associated with effective health communication. For example, it should be persuasive and timely (and attractive!). So let us be clear: We're *not* saying that that these 4 attributes alone are what make quality health communication. Rather, we're saying that we've chosen to emphasize these 4 attributes in the context of our efforts to center health literacy and health equity. And in doing so, we're improving the accessibility and the quality of our communications.

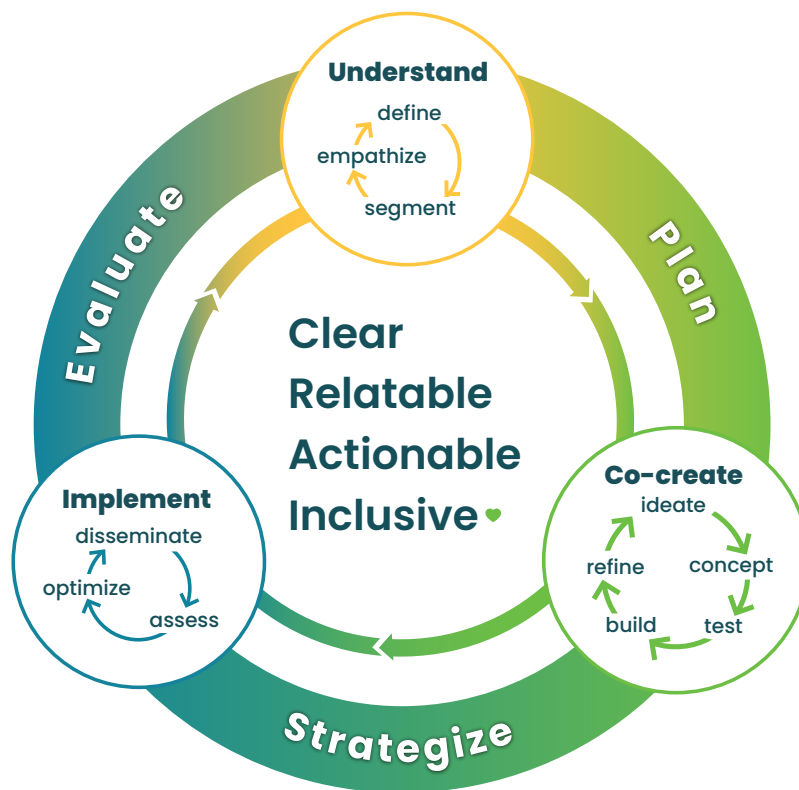
Here's how we do it.



It's our collective responsibility to lower barriers to health.



A Framework for Equity-Centered Health Communication



Graphic: The Equity-Centered Health Communication Process

This graphic shows the basic stages of the health communication process (as described in the Pink Book), along with iterative cycles inspired by human-centered design. We center the equitable outcomes we strive for: health information that’s clear, relatable, actionable, and inclusive. This approach ensures empathy and inclusion are baked into the project at every step of the process — not just retrofitted at the dissemination and outreach phase.

What’s not represented in this graphic is the messy overlap of identities — and the backtracking and iterating that needs to happen when we apply this process to real-world scenarios. An equity-centered approach requires us to empathize with the people we want to reach, learn from our audiences, and *unlearn* old methods and ways of thinking — not just at the beginning or the end of a project, but throughout the project lifecycle.

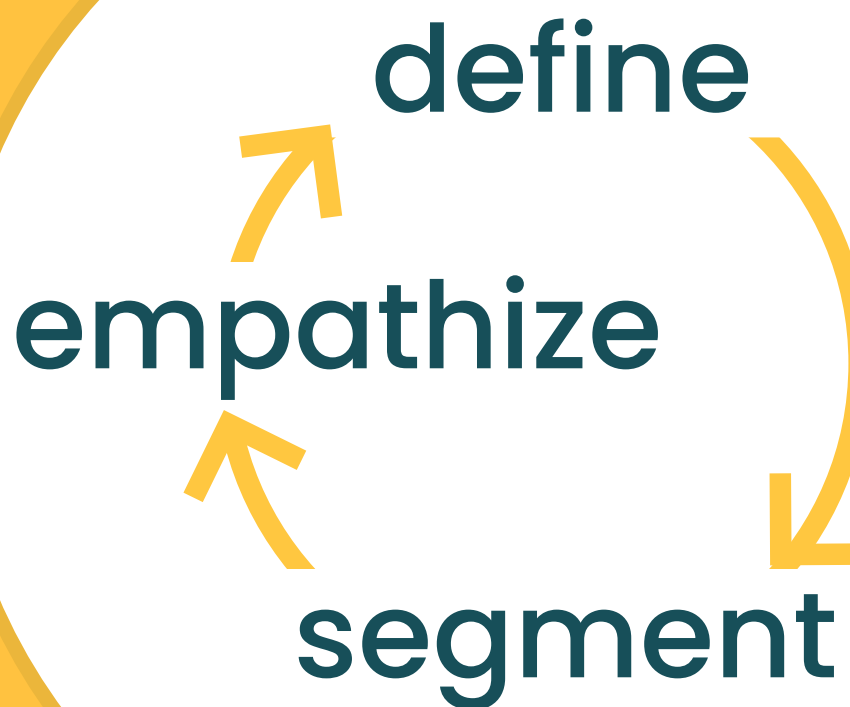
Our equity-centered framework diverges from the traditional human-centered design model — pioneered by the design firm IDEO — in a couple notable ways:

- Practitioners of the human-centered design process are typically designing *products*. While human-centered design has evolved to take a more holistic view of the *systems* in which people use digital products, the process typically starts with a “blue sky” approach of asking the end user what they need. Rarely do we have this luxury in the under-resourced world of public health. In our work, the problem (and sometimes even the solution) is often identified by our funders or clients. But even in this scenario, there’s ample opportunity to define and design **with** affected community members rather than **for** them.
- Traditional human-centered design is based on the idea that there’s a single elegant solution that works for all (solving the problems of the “average user”). In this pursuit, human-centered design can dismiss “others” as edge cases. As communication professionals, we know that there’s no “general population.” If we use our own experiences and abilities as a starting point, we end up with communications that ignore much of the diversity of humanity. In public health, we often need multiple solutions (or iterations of a solution) to meet the unique information needs of our audiences.

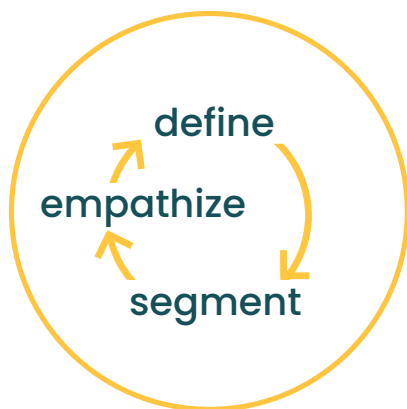
Our equity-centered framework is flexible enough to apply to a wide variety of health communication interventions — from large national communication campaigns to service delivery design to the creation of digital health information products.

Author's note: In the following sections, we present a set of tips and considerations for each phase of the equity-centered health communication framework. These are by no means exhaustive, nor do they represent a step-by-step “how-to” for health communication. Instead, we propose specific questions and considerations — the “shifts” in methods and mindsets mentioned earlier — to help you center equity in your own health communication practice.

Phase 1: Understand



Phase 1: Understand



Some of the most impactful shifts in our health communication practice happen at the beginning, in the Understand phase.

This phase has 3 main steps:

- **Define the health communication problem as you know it.** We look to public health data and previous research to see where knowledge gaps or beliefs and perceptions may be influencing behaviors and contributing to poor health outcomes.
- **Identify your audience.** In public health, our priority audiences are often communities who are disproportionately affected by the problem, overlooked by past communication efforts, or both. In this process, try to narrow to the most specific audience segments possible so that your messages have the greatest chance of success.
- **Listen to and learn from your priority audiences.** This helps us challenge our assumptions and biases and empathize with how our audiences see, feel, and experience the problem — in the context of *their* health. We learn what drives them, what gets in the way, and how health literacy may play a role in their health decision-making. Insights from this step influence our understanding of the problem (hence the iterative cycle).



Define the problem

First, you need to clearly identify the health communication problem you're trying to solve. Ask yourself:

- ☐ How can you let the experiences of the affected community inform your understanding of the problem?
- ☐ Are you looking at the problem from all angles? Consider the hypothetical example of adolescent mental health. Is the problem that white teens have higher rates of mental health conditions than teens of color, or is it that teens of color are less likely to receive a diagnosis than their white peers? The framing of the problem impacts everything from public perception to intervention design.
- ☐ Examine power constructs and dynamics. Who is benefitting from the status quo? Who should be in the position to drive change?
- ☐ Consider your role as a public health professional. How did public health policies and practices of the past contribute to the current situation? How have your own communication practices created unnecessary barriers to access and understanding?
- ☐ Who has been the focus of past communication efforts? Who has been left out or not yet prioritized?

An equity-centered approach requires us to unlearn old methods and ways of thinking.

Identify and segment your audience


One of the most important steps in any health communication project is to identify our intended audience segments, or subgroups. In health communication, we segment audiences using varying characteristics — the most common being demographic (e.g., age, education, or income).

In an equity-centered practice, it's critical that we:

- **Go beyond demographics.** Specific behaviors, cultural practices, social and physical environment, values and beliefs, or other theory-based characteristics (e.g., readiness to change) can help us characterize groups in more meaningful ways.³
- **Account for overlapping identities.** In other words, we must be mindful of intersectionality within audience segments. (Remember, identity is messy!)

Here are some considerations for exploring and addressing the complexity of identity:

- Are you recognizing diversity and intersectionality *within* demographic segments and not just between them? For example, if your audience segment is Black women, are you accounting for women who are Black *and* bisexual, disabled, or Deaf? What about biracial women who identify as Black? Have you considered the role of gender expression or colorism (i.e., skin tone bias) in shaping individual identity?

- 
- How can you create health communications that are truly transformative in dismantling stereotypes and driving equity and inclusion? A stereotype is an exaggerated belief or assumption about a person or group — a generalization that doesn't account for the unique experience of individuals.
 - When writing about different identities, it's important to use the right level of specificity. For example, when referring to women, consider whether you're referring to cisgender women, transgender women, or both. If you're talking about pregnancy, a nongendered term like "people" may be more inclusive.

A note on the language of identity

The language we use to describe people and their identities is constantly evolving. In health communication, we typically learn to default to people-first language ("person with diabetes," not "diabetic"). That generally comes from an effort to be respectful, to avoid defining a whole person by one part of them. But when it comes to reflecting other people's diverse identities, there really is no "default" — and some groups advocate for identity-first language ("autistic person," not "person with autism") so as *not* to separate that part of them from their identity.

And that's why we try to learn from our audiences (whether in formative research or more informally) — which terms do *they* use? What do *they* prefer? We've made some very intentional language choices in this framework, including the use of "disabled people," and we recognize that these choices may not work for everyone. But we *can* confirm that we made them thoughtfully — and with input from people with lived experience. Words are powerful. As health communicators, we have an opportunity to create products that make *everyone* feel seen, included, and respected.

Empathize with your audiences — listen, learn, and reflect

Next, it's time to connect with our priority audiences through conversation, observation, listening, empathy, and humility. This can happen in different ways, and there's a continuum in terms of formality. For example, you can conduct formative research — like focus groups or in-depth interviews — with audience members. But you can also get valuable feedback from people from your professional networks or social circles, or by tuning into digital conversations relevant to your audiences — through social media, advocacy websites, or message boards.

Regardless of the method, engaging with empathy helps us understand the full context of the problem. And empathy and objectivity in public health are *not* mutually exclusive — there's room for both! Try these tips to empathize with your audiences:

- ❑ Engage community experts rather than relying solely on traditional academic subject matter experts.
- ❑ Always ask! Don't make assumptions about audience preferences or level of understanding.
- ❑ Pay formative research participants fairly for their time and expertise.
- ❑ Consider your own positionality and implicit biases in conducting formative research. Positionality refers to how our own identities and experiences influence how we carry out a study, including the way others see us and give us power in a specific research context.
- ❑ Finally, reflect on what you heard. How has your understanding of the audiences or the problem evolved?



Empathy and objectivity in public health are not mutually exclusive.



Perceptions and power

Equity-centered health communication requires empathy and humility. Humility in health communication is the practice of self-reflection on how our own background and biases impact every aspect of the communication process. And this includes an examination of power dynamics and imbalances in our work.

Here are some considerations for self-reflection:

- ☐ Examine power dynamics within the project: Are you designing **with** the community being impacted or **for** them? Do the people making decisions reflect the population who will be impacted by the intervention?
- ☐ How do your identity, background, and beliefs impact your professional practice?



Next Up: Plan



Planning is not confined to a single step in the communication process, of course. Nevertheless, once we have a clearer picture of the problem and the priority audiences affected by the problem, it's a good time to set communication goals and objectives. If the ultimate goal is to change behavior, how will we get there? Social science theory can help explain the relationship between factors like individual knowledge, self-efficacy, perceived benefits and barriers, and intent to engage in specific health behaviors.






Communication alone can't achieve all objectives or solve all problems.



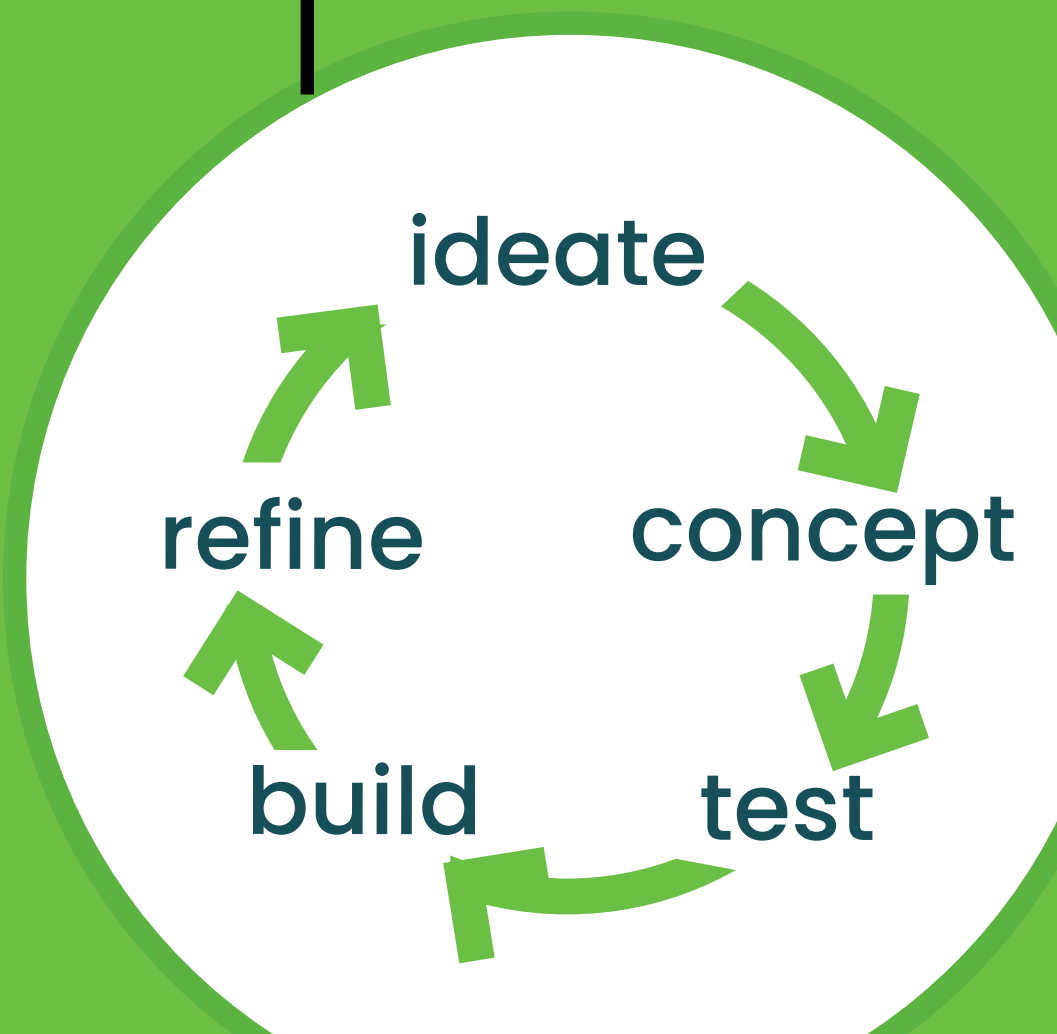
In an equity-centered approach, we're also examining the impact of power — including historical and present-day systems of oppression — on human behavior. We're seeking to change attitudes and behavior — and, more often than not, to shift power to historically under-resourced groups.

Here are some considerations for centering equity during the initial planning phase:

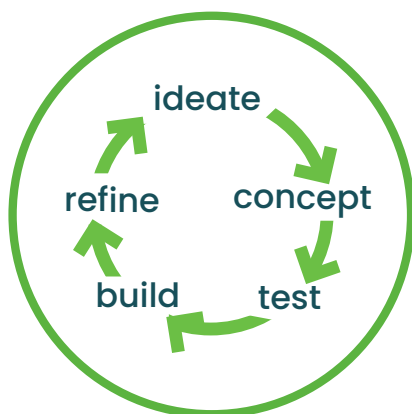
-  **Set realistic objectives.** The Pink Book reminds us that communication alone can't achieve all objectives or solve all problems. The authors encourage us to be reasonable when defining our communication objectives by asking: What can communication feasibly contribute to attaining this goal? Similarly, as you draw on communication theory and behavioral science to inform your initiative, it's critical to keep in mind that individual behavior change doesn't compensate for decades of underinvestment in access to health care, education, and safe built environment.
-  **Pay attention to negative vs. positive framing.** It's tempting to identify a list of risk factors, but what about protective factors? Remember to look for the bright spots!
-  **Consider how the experiences of community experts will inform your communication strategy.** This includes your objectives, activities, and partnerships.



Phase 2: Co-create



Phase 2: Co-create

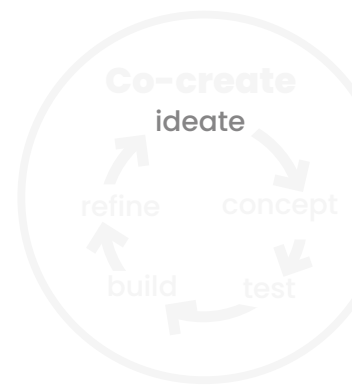


In this phase, we begin to move from planning and discovery to tangible intervention design. Whether it's a full-scale communication campaign or some new digital content, the basic steps of the co-creation phase are the same.

In an equity-centered communication practice, the emphasis is on learning and refining in partnership with our priority audiences — we must maintain clear, consistent channels for audience members and stakeholders to share feedback, especially those directly impacted by the problem we're trying to address.

The basic steps of this phase include:

- **Ideating** approaches
- Developing creative and message **concepts**
- **Pre-testing** these concepts with community members
- **Building** accessible products
- Learning and **refining**



Ideate approaches

It can be tempting to jump to solutions as soon as we have a solid understanding of the problem, which is why the ideation stage is so important. It forces us to imagine new and better ways of doing things. Ideating is a time to *create* choices rather than to make them.

Most practitioners of public health communication are public servants — or at least funded by public institutions. We're accustomed to working with small budgets and limited resources on short timelines. So it's our natural inclination to constrain public health problems and restrict choices in favor of doing what we know works — or what's been done before.

In an equity-centered approach, we must question whether these “best practices,” effective as they may be, are enough. Do they actually solve the problem? And do they solve it for the communities most impacted?

Here are some questions to drive iteration on potential solutions:




- ☐ How do your own interests and expertise impact the types of ideas proposed?
- ☐ Will your solution be enough? Will it solve the problem?
- ☐ What constraints are you assuming? What new ideas arise if you remove those constraints?

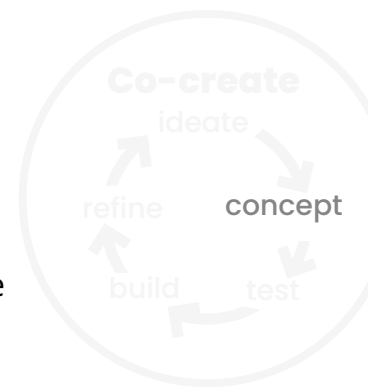
Ideating is a time to create choices rather than to make them.

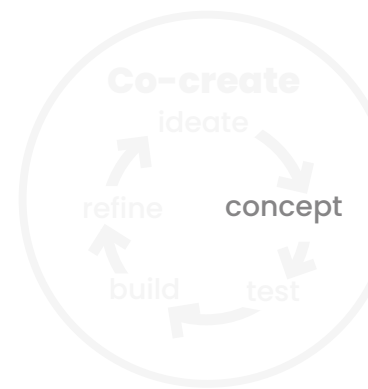
Craft communication concepts that resonate


The next step in this phase is to develop creative and message concepts — these are general ideas and directions, not final products. Adopt an inclusion mindset from the get-go — remember, we create space for a diverse range of identities through our words and images.

Here are some considerations for drafting inclusive message concepts:

-  **Lead with empathy.** This is important in our work and in our writing. As public health practitioners, it's critical to connect with our audiences *before* offering them guidance. This has long been a tenet of effective crisis communication,⁶ and it applies to non-emergency contexts, too. When you address what people are feeling and the challenges they face, you build trust and rapport.
-  **Modify voice and tone to match the content of your message and your audience's likely emotional state.** For example, if you're promoting heart health, messages about adding some physical activity to your day should sound different from messages about the health effects related to the stress of regularly experiencing discrimination, microaggressions, and other types of interpersonal racism.
-  **Use familiar language.** At CommunicateHealth, we can't emphasize this enough. Clear communication *is* inclusive communication.






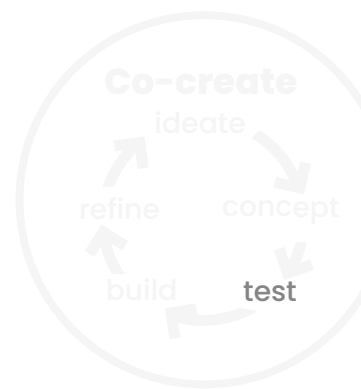


 **Counter stigma and shame.** Our health is extremely personal, and for some of us — whether it’s because of our gender identity, sexual orientation, ability, race and ethnicity, health status, economic status, or other lived experience — it can be a source of shame. As health communicators, we know that stigma and shame get in the way of good health decisions and make it harder for people to access and understand health information. So counter stigma and shame in your writing by normalizing a diverse range of human experiences and acknowledging barriers to health behaviors.

Author’s note: There are many style guides out there with excellent recommendations on how to talk about topics such as race, sexual orientation, and health disparities. As a starting place, we recommend [CDC’s Health Equity Guiding Principles for Inclusive Communication](#).⁷

Here are some considerations for drafting creative concepts:



-  When choosing images, make space for different identities and experiences. When people can see themselves in your communications, they’re more likely to pay attention to and follow your recommendations.
-  Watch out for overly posed or fake stock photos.
-  Go beyond representing diversity in your photos and images to truly transforming the portrayal of family composition, social class, race and ethnicity, gender, and ability.



Pre-test concepts

Message and creative concepts are often a tricky, well, *concept* for community members (and clients!) to wrap their heads around. That's why it's important to take extra time to explain the idea at the beginning of the feedback session ("these are rough drafts" or "these are just a sketch"). Focus groups and one-on-one interviews work great for this.

Here are some things to keep top of mind as you pre-test your concepts:


-  **Recruitment.** It's critical to recruit and test concepts with diverse members of your priority audience. Take extra steps to recruit participants who are likely to have limited health literacy skills, limited access to broadband internet, or situational or permanent disabilities.
-  **Constructs for testing.** For example, you may want to ask questions that help determine cultural appropriateness and responsiveness, comprehension, persuasiveness, usefulness, credibility, and relatability. Be sure to use familiar language and examples in your moderator's guide.


Sample participant questions


- What do you think is the most important information in this material?
- What, if anything, feels especially relevant to you personally?
- How does this material make you feel? What, if anything, makes you feel happy or positive?
- What, if anything, in this material bothers you or maybe rubs you the wrong way?
- Who, if anyone, do you think this material is for? What makes you think that?

Tips for remote testing

- Do a tech check at the start of *every* session to make sure everyone's comfortable with the format and all the technology is behaving.
- Plan ahead for issues that might come up — for example, have a team member on deck to address tech issues or book slightly longer-than-usual sessions in case you need to extend due to tech-related delays.
- Take time to build rapport before you dive into the subject matter.
- Consider seeking out recruiters or community partners who can provide internet access and distribute materials for remote testing.

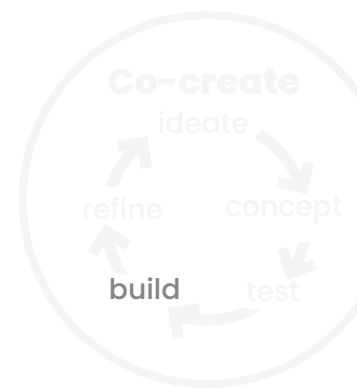
 **Methods.** Consider how you're grouping people and whether a one-on-one session may be more appropriate. Individual interviews, which can allow for extra time, work better for participants with limited literacy skills and when you'll be discussing a sensitive topic. On the flip side, focus groups are great if you think that group dynamics and participant interaction will yield richer qualitative data.

 **Logistics.** If you're testing in person, choose a familiar location that's easily accessible, like a local senior center or library. And always pay research participants fairly for their time and expertise.

 **Equipment.** When testing digital tools and websites, let participants use their own phone (you provide the free Wi-Fi) if possible. It's a win-win: They'll be more comfortable with their own device, and you'll get more accurate data.

Considerations for recruiting diverse participants




- Partner with community organizations on recruits.
- Allow for longer recruitment periods — at least 3 to 4 weeks.
- Set specific quotas for the type of participants you're looking for.
- Write recruitment communications and consent forms in plain language.
- Provide cash or gift card incentives when appropriate. (And if you're testing in person, don't forget the food!)




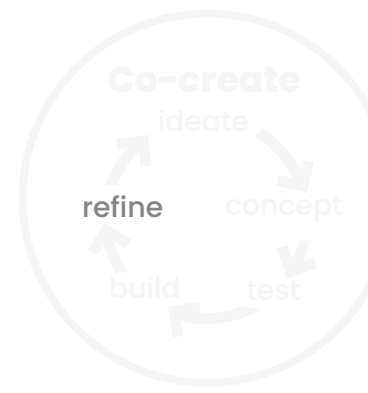
Build accessible communication products

We aim to create communication products that help people access, understand, and use health information. This includes addressing physical, digital, and content-related barriers to participation.

Here are some tips for developing products that work for everyone:

-  **Limit the amount and complexity of text.** Plain language PSA: This does *not* mean “dumbing down” your materials! What it does mean is not forcing people to do mental gymnastics to grasp new terms and phrases when everyday words will get the job done. Always lead with the most important information and let users decide if they’ll drill down for more details.
-  **Design for edge cases.** The most obvious example of this is the continuum from temporary to permanent disability. By ensuring that a digital health tool is easy for a person with one arm to access and use, you’re also expanding access to an older adult with a wrist injury or a new parent holding a baby.
-  **Account for broadband access and load time.** It’s estimated that more than 40 million Americans lack access to broadband internet.⁸ In rural and tribal lands, 1 in 4 residents don’t have reliable internet access.⁹ The reality is that if your webpage takes 10 seconds to load, you’ve likely lost your audience. Create lightweight, accessible digital products that don’t eat up limited data.

 **Go beyond Section 508 compliance.** All federal government websites need to be accessible to disabled people — for example, they need to work with screen readers, keyboard controls, and other assistive technologies. This is called Section 508 compliance. But in an equity-centered practice, accessibility is about much more than a compliance checklist. Accessibility is the result of an inclusive design process that centers the needs and preferences of disabled people, older adults, and others with limited experience with technology. By designing for these user needs first, you create digital products that are easier for everyone to understand and use.



Accessibility is much more than a compliance checklist.

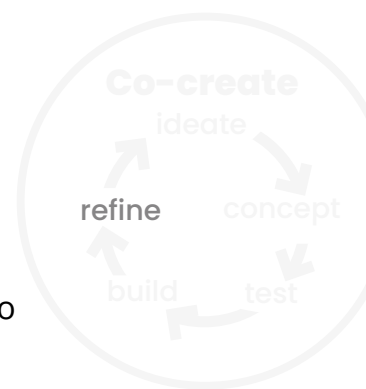


Learn and refine

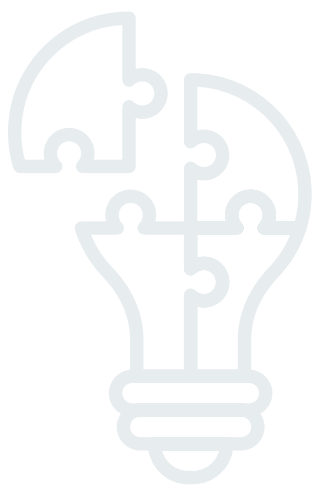
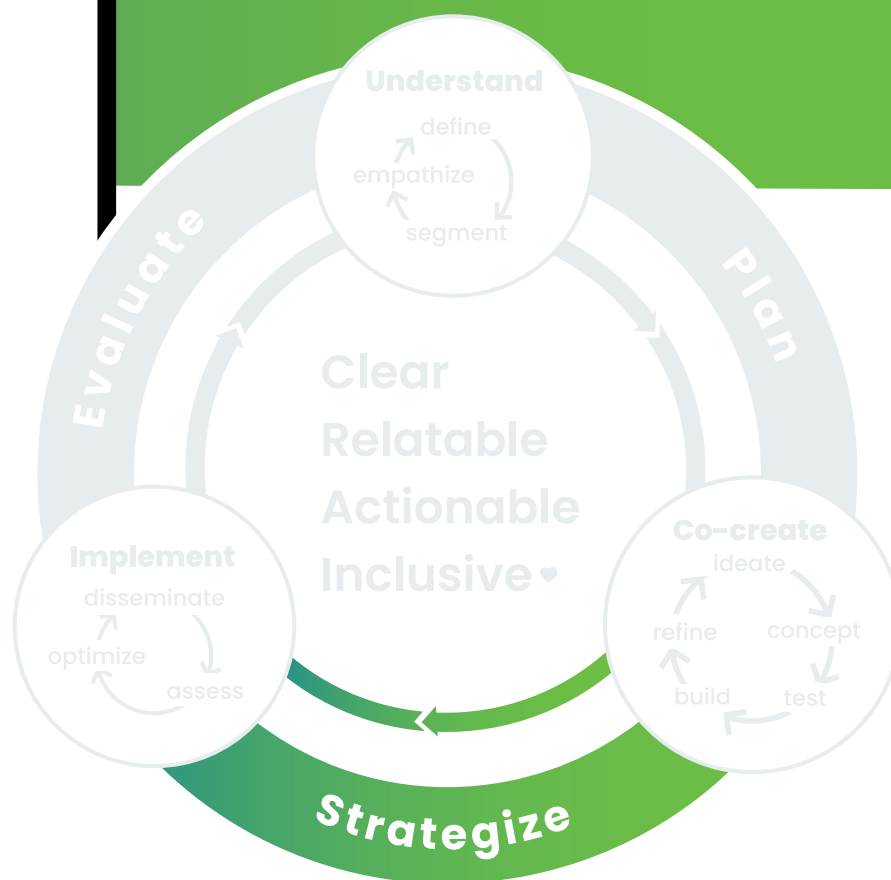
In many human-centered design models, this is represented as a continuous feedback loop, repeating indefinitely. This would require infinite time and resources — something that no public health project has. But a solid round of testing before implementation is important. It's also a great opportunity to enlist additional community experts and explore alternative methodologies.

In addition to the research considerations from the pre-testing phase, here are a few more:

- ☐ Check specific word and image choices — details that may not have been fully fleshed out in earlier rounds of testing.
- ☐ Circle back with participants from earlier research phases to see how you did implementing their suggestions. This further solidifies their role as community experts.
- ☐ Start thinking about implementation (Phase 3). For example, this is a great time to ask participants how they'd prefer to learn about this product or initiative.



Next Up: Strategize






Health communication is all about reaching the right people with the right message at the right time. And this strategy stage is when you plan to do exactly that.

It's time to consider:

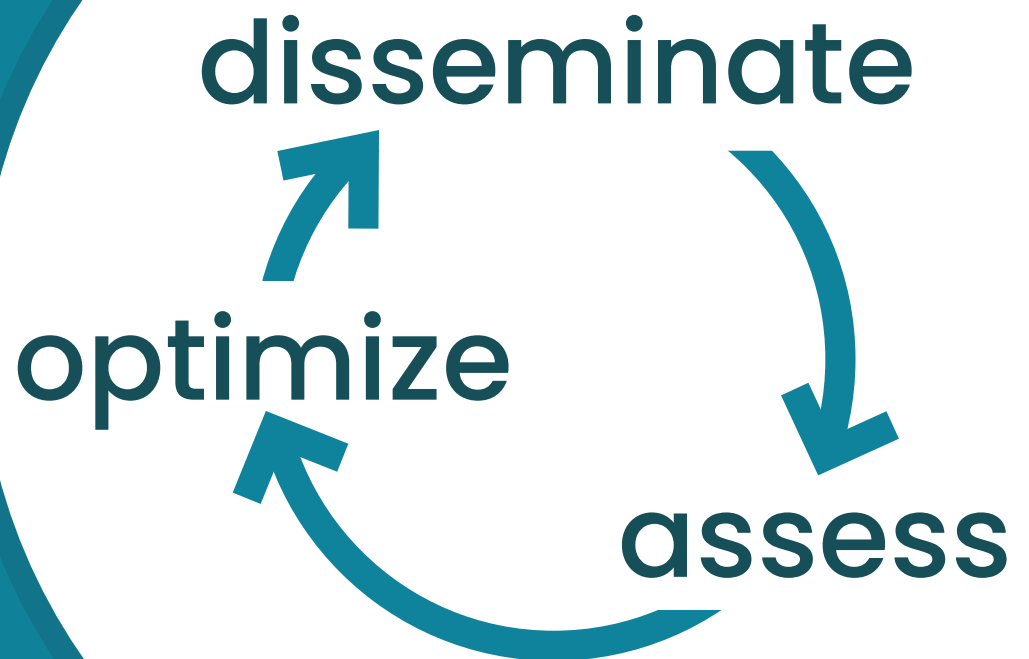
- ☐ Who are your trusted messengers and ambassadors?
- ☐ What channels are you using?
- ☐ When is the right time to reach your audience? And how often (i.e., consider message saturation)?
- ☐ How are you determining success?

In an equity-centered practice, we take a slightly more nuanced approach to these questions. Here are a few tips to help you do that:

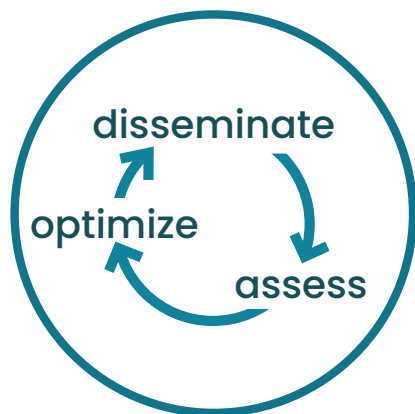
-  Consider how the intersections of race, class, ability, sexual orientation, and gender identity will affect community members' engagement with and response to your messaging.
-  Anticipate diversity of context and experience — like varied access to reliable broadband internet, level of trust in public institutions, exposure to disinformation, mental health status, and readiness to engage.
-  Plan ahead for evaluation — don't wait until the end of your project to craft your evaluation strategy. This gives you the time and space to intentionally choose metrics that drive equity, accountability, and sustainability (we discuss this further in the Evaluate section on page 42).



Phase 3: Implement



Phase 3: Implement



Regardless of the size or scope of our health communication intervention, successful implementation requires effective management, strong partnerships, and frequent communication.¹⁰ In our model, we also need political and organizational commitments to equity and inclusion — plus a hefty dose of humility.

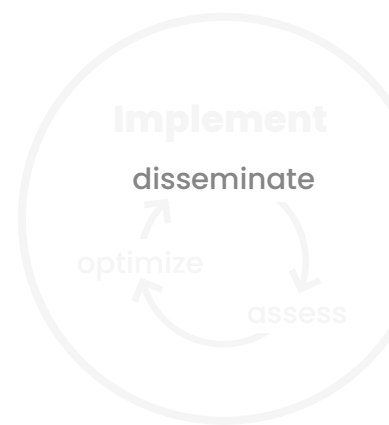
This phase involves:

- Building diverse networks to help **disseminate** your message
- Creating opportunities to **assess** impact as you go
- Circling back to **optimize** your approach, sometimes in real time

Build diverse networks for dissemination

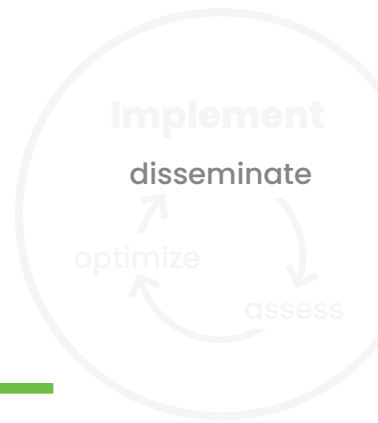
Partnerships can help us bolster our credibility and broaden our reach. We enlist community members — including influencers, relatable peers, and early adopters — to help communicate our messages. Keep in mind that during times of stress, people are more likely to take advice from a familiar, trusted source.⁶

In the context of public health communication, partnerships often come together around outreach opportunities and other short-term “wins.” This can make the relationships feel transactional and... uncomfortable. In an equity-centered practice, community partnerships require continued investment of time and resources — which means this work can’t start when we get to Phase 3 in the process.





Over time, this helps shift power to communities most affected by inequities.



The good news is that building community power — like by creating infrastructure that allows for community ownership and developing community leaders — can carry over from one intervention to another. Over time, this helps shift power to the communities who are most affected by inequities.^{11,12}

Here are some questions that can help you forge and cultivate these critical partnerships:

- ☐ How are you elevating the voices of community partners and experts with lived experience?
- ☐ Are you centering the community's priorities over your own?
- ☐ How can you acknowledge and leverage the strengths and specific expertise each partner brings to the table without confining their input to these areas?
- ☐ Are you intentionally building community power in the long term? Are you creating infrastructure that facilitates community ownership? Are you developing community capacity to lead? Is there mutual accountability?
- ☐ Who's getting credit? And who benefits?

Assess impact as you go

Consider developing a process for regular “equity checks.” Use these informal assessments to reflect on everything from power imbalances on the team to the accessibility of your communications.

Here are some questions to help you create opportunities for real-time impact assessment:

- ☐ How are you sharing meaningful process data with affected community members?
- ☐ Does your data collection and analysis enable you to capture the experiences of people with overlapping identities and compounded experiences (e.g., a bisexual Black woman)? Typically, this means advocating for disaggregated data — data that you can break down and analyze by race and ethnicity, gender, disability, income, Veteran status, age, or other key demographic variables.¹³

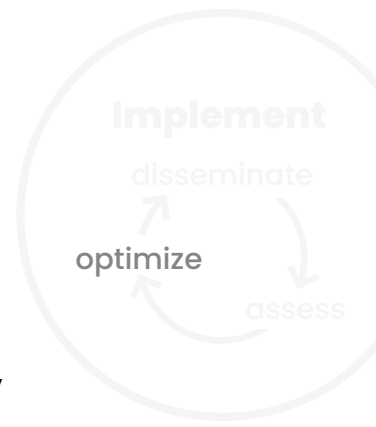


Optimize your approach (aka stay humble)

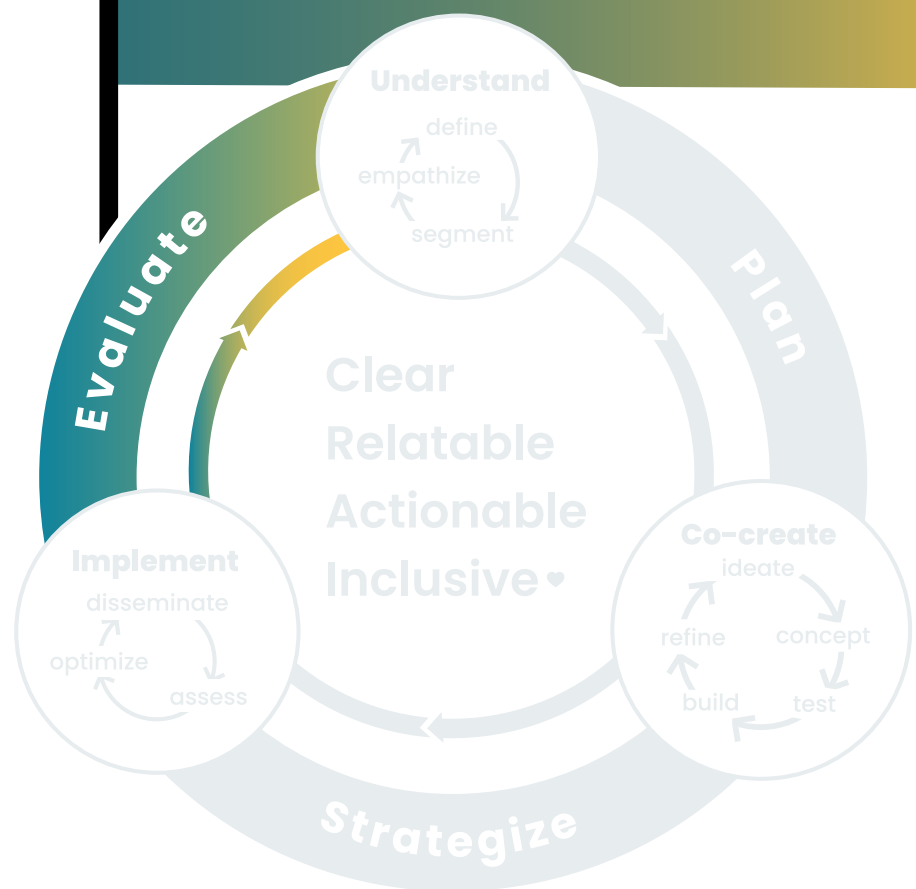
Just like we use real-time data to optimize digital content for maximum engagement, we can use real-time learning and reflection to optimize our communication approach for equity and inclusion.

An equity-centered mindset requires empathy (to listen) and humility (to acknowledge our biases and gaps in understanding). Keep in mind:

- ❑ **Language is constantly evolving.** Our identities also evolve over time. Acknowledging and supporting this evolution is critical to your practice.
- ❑ **You *will* make mistakes, and that's okay.** It's how you respond to and learn from them that's important.



Next Up: Evaluate



As we seek to shift our public health systems toward equity and justice, we have to adapt our methods of measurement, evaluation, and learning. In an equity-centered health communication practice, we’re evaluating not just what works — but what works for whom and under what conditions? Did we make an impact in the places where it was most needed?

Use measures that reflect both **process evaluation** (e.g., Do decision-makers reflect the priority audience? Were participants informed about how their input was or wasn't incorporated and why?) and **outcome evaluation** (e.g., What impact did the intervention have on specific populations? Did it improve or exacerbate racial, gender, disability, and other access inequities?).

As you prepare to evaluate your health communication intervention, it's important to consider:

- Accessibility and cultural relevance of data collection instruments
- Compensation for community members and experts with lived experience
- Format for sharing meaningful data with community members

Here are some questions to drive equity-centered evaluation:

- ☐ What outcomes are most meaningful to community members?
- ☐ Have you considered sustainability and environmental impact?
- ☐ Who should be involved in selecting the evaluation measures and collecting data?
- ☐ Are there opportunities to build community capacity in evaluation?
- ☐ Who has a say in how data should be used?



References

- ¹ <https://www.cdc.gov/about/cdc-moving-forward/index.html>
- ² <https://www.cdc.gov/healthliteracy/learn/index.html>
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- ⁶ <https://emergency.cdc.gov/cerc/manual/index.asp>
- ⁷ https://www.cdc.gov/healthcommunication/Health_Equity.html
- ⁸ <https://www.pewtrusts.org/en/research-and-analysis/articles/2022/03/29/states-considering-range-of-options-to-bring-broadband-to-rural-america>
- ⁹ <https://www.usda.gov/broadband>
- ¹⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3910052>
- ¹¹ https://www.urban.org/sites/default/files/publication/104252/building-community-power-for-equity_0.pdf
- ¹² <https://nam.edu/building-community-power-to-achieve-health-and-racial-equity-principles-to-guide-transformative-partnerships-with-local-communities>
- ¹³ <https://www.whitehouse.gov/wp-content/uploads/2022/04/eo13985-vision-for-equitable-data.pdf>

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We acknowledge, with humility, that dismantling systemic oppression will take collective effort, courage, and commitment. We present this framework as a starting point — a tool to prompt reflection, awareness, dialogue, and action. And we look forward to participating in these critical conversations with our colleagues, partners, and friends in the public health communication community.

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