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**Inclusive Public Health Communication Workshop Series:
Understanding and Reaching Your Audience**

Monday, May 2, 2022, 3:00pm - 4:00pm ET

DR EMILY HOTEZ:

Hi, everyone! My name is Emily Hotez, I am an assistant professor at UCLA's department of medicine. I am thrilled to be with you for our second workshop in our inclusive public health workshop series--.

I am joined today with my colleague Asal Bastani from UCLA, as well as my colleagues from AUCD. Most importantly, I am joined by my colleague Doctor Neecey Hudson, from the Hood Medicine initiative.

Doctor Hudson is an expert in all things public health communication. Our first workshop focused on public health communication 101, and you can find the linkage to that through AUCD's website, and we can probably pop that in the chat also.

This workshop will be a little bit more specific, and tailored to how we as public health communicators and messengers can really target exactly who we would like to in our audience.

How do we reach those people who we really want to reach? How do we move beyond outreach to marginalized groups in a way that conceptualizes them as a homogenous? And is able to capture the nuanced differences within various target populations?

We are thrilled to be with you today. Please, throughout this workshop, drop questions in the chat, unmute yourselves. We certainly encourage interaction and discussion, rather than simply talking at you.

So, please don't be shy!

With that, I will let Doctor Hudson a take it away!

SPEAKER:

Quick note, I want to tell people that CART captioning is available. It should be on the bottom right of your screen. You should be able to hit the 'Closed caption' button if you need captioning. Please do try to estate muted when other people are talking.

As Emily mentioned, if you have a question during the question and answer period, you can come off mute and ask that. Otherwise, drop questions in the chat if you can. Or you can message Charisse or me. My name is Steph, but my account is the AUCD communications team account. You can message as if you need any tech support help, and we can try to help.

Sorry, Doctor Hudson, go ahead!

DR NEECEY HUDSON:

Sure. There we go.

Thank you for having us today. As Doctor Hotez mentioned, we want to open a discussion, and leave you with your own with -- own thoughts with what it means to connect with your audience. Whether or not you even know who those people aren't what they are like.

Do you want to advance the slides?

SPEAKER:

Doctor Hudson, I can hardly hear you.

DR NEECEY HUDSON:

Sorry about that! Is that better?

DR EMILY HOTEZ:

Yes! That's better!

SPEAKER:

Much better! Thank you!

DR NEECEY HUDSON:

We are going to start with a survey question for everyone. We are assuming you are here because you are trying to understand your audience and so: in your perception, what is the biggest hurdle you had in reaching people during the pandemic?

Asal, maybe the screen ratio is off, so the cure our code may be off. Thank you. -- QR code.

ASAL BASTANI:

Is that better?

DR NEECEY HUDSON:

Yes.

I will give you guys a couple seconds to reply to that. We will look back at your answers in a little bit.

Emily, if you could drop that link in the chat. In case anyone is having trouble accessing it.

We can move to the next slide.

Previously, we have started off with a broad discussion of public health communications, what therefore,--they're for, and how to design messaging that emphasizes a particular call to action or behavioral change, and how a lot of those methods are grounded in psychology and social science, and communication, and different frameworks that we utilized in various ways to put things together to have a coherent message, and to motivate clear action.

Who is your audience? Obviously, we are focused on patient populations, from a neurodiversity, intellectually and developmentally disabled communities. Having that as your framework, think about self-identity, how people view themselves, how they define themselves, their interpersonal dynamics, with their families and close friends... their ideologies, which can be influenced by their culture or society and their class, different socioeconomic factors.

At the same time, I think in order to have a whole full discussion, and view our audience as full, whole people, we also have to think about their fears, hopes, and burdens that they are carrying. That's important because otherwise, how do you know what you are trying to overcome in getting your message across to them?

Obviously, those sorts of social determinants of health are going to be influenced, again, by class, privilege, and society, by accessing resources,--access and resources, and obviously by the type of support systems that people have to carry them through in terms of whatever particular medical issues they are dealing with.

When we start to parse that out a little bit... In our work at Hood Medicine with Doctor Hotez we are always looking at everything from an intersectional lens, and again, looking at people in the fullness of everything that they are, who they are, who they proclaim themselves to be. Not our own biases about who we think they are, and that does involve some insight and empathy, and some critical thought about the society that we live in.

If you can imagine, that is really hard to do if you are--your worldview and frame is more oriented towards... I guess there's not a better way to say it, and we don't really utilize in hood medicine, but it's kind of like a 'Hood--'victim blaming', our lenses focus on areas that are disadvantaged, and not as critically focused on the broken institutions that perpetuate that condition.

So our frame from the onset should always be that people are intersectional in their identity, that that differentially affects the experiences that they have, how they move through life, and when you are thinking about patient populations that does mean that it very much diversifies and multiplies the veins of messaging that you really have to consider if you are interested in reaching all people for all things.

Obviously, (Audio Issues)... language considerations, accessibility considerations, religion, culture, gender identity, disability. Again, all of the societal and interpersonal dynamics, and not just in terms of ownership or labeling, do you know what I mean? We are not putting onus of

these characterizations on the patient population should bear frame of mind.

Rather, you are challenging yourself to think really critically about how our society is structured to allow this to perpetuate. That is our frame of mind as we move forward.

I thought we would do a quick mock profile. Hopefully, we can maybe get you guys to drop some comments for some of the questions that we have, or maybe do a quick survey with emojis if you are able, and get some feedback from the group on how you would approach some of these considerations.

So, Asal, do you want to take us through the profile that you put together?

ASAL BASTANI:

Yes. This is a mock profile of Anthony. He is a black, artistic, queer individual -- autistic, he has a tight family, a good job, and lives in a liberal town. And these bars show he has a high support, he does seek knowledge to an extent, and he has indifferent healthcare. That means they are not super considerate of the accommodations he might need.

DR NEECEY HUDSON:

So, thinking about someone like Anthony, maybe you guys can drop in the comments some of the things that immediately come to mind about what his challenges might be in life. Assuming that he identifies as a 'He'.

Emily, what do you think? I'll start with you before we get comments going. (Laughs)

DR EMILY HOTEZ:

Sure. And, you can drop in the chat, or you can unmute yourself or raise your hand and unmute yourself to contribute.

The first thing that jumps out to me, obviously, is we are looking at the gradation's of support, knowledge, and healthcare. And we see that he has in different healthcare. Yes, exactly, Megan, that is the issue that jumps out at me first two. If the healthcare... if his healthcare is not responsive to his specific needs, experiences, priorities,... exactly, great point in the chat!... Then I would worry that some of his physical or mental health experiences might be unmet, and that would be where I would first look. But there are some great suggestions in the chat here.

I am seeing (Reads) Trust in the healthcare system. Exactly Jennifer (Reads) Medical professionals might not prioritize the issues. (Reads) Lack of access to knowledge about preventative healthcare. I like that, Monica, (Reads) Messaging may not take account gender dysphoria that they may experience was the and the messaging may not be responsive to the way that they process information.

Monica is really touching on the communication that might be animating from the healthcare system.

DR NEECEY HUDSON:

I also want to point out from up personal perspective, or considering Anthony's personal, interpersonal interactions, there may be also, there could have been, obviously, opportunities where he may have experienced bullying, or a lack of support from family or educational support systems, things like that. Think about things over the life course that influence the self beliefs that people develop, and the fears and anxieties that they have about how society perceives them as well.

DR EMILY HOTEZ:

And this issue is brought up in the chat as well, but... one example of what Doctor Hudson is talking about, as many of us know, is that when neurodivergent people go to the doctor, often times at the doctor only addresses their caregiver, their parents, or some other kind of pair giver, rather than speaking directly to them because they may assume that they may not understand, or some like that.

In the chat was brought up that there is a lot of strengths with his family. It's a tightknit family, he has a lot of support, but that might also make me think that perhaps his healthcare provider might often times do things like only talk to the caregiver because they know that the caregiver is such a great support system in their lives, and it just makes sense to talk to them instead of talk directly to Anthony. That might be something that Anthony is experiencing.

DR NEECEY HUDSON:

, When the last nuanced point is that -- one last nuanced point is that he lives in a liberal town, has good support, good family, and I think it's great that Asal chose these positively leading characteristics about his work/home life. There is always the potential for inherent bias against people and marginalized groups. Presume that they all have this a ghetto lifestyle, or just don't have regular problems. (Laughs)

Like, people in different class levels, who live in different neighborhoods besides the hood may have. So it's another quiet points that it certainly encourages you to, I hope, throughout all of this, to recognize that black people, or any other ethnic group should never be considered monolithic, as a monolithic entity. There are very clearly defined stereotypical ways in which we perceive that we should message to some of these ethnic-based, marginalized communities, Ace on the way-- based on the way --

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DR NEECEY HUDSON:

But that's not always the way. I think there are all sorts of ways to learn from different things, to draw from to make compelling messages to reach people, to disseminate health education.

I do think that we need to expand our mind about the ways that we conceptualize different ethnic communities, and also that they are just as diverse within the community as the world is without, if that makes sense.

If we focus in on Anthony's healthcare experience. The kinds of things we like to do to start and take a walk in someone else's shoes, and I think a lot of people have expressed a lot of these considerations in the comments, is that, like many of us, we are going through a sea of information in different, various ways, depending how we are interacting with the healthcare system. There will be perceptions that we have internally, there will be perceptions that people have of us that are external, and then, obviously, there are actions in terms of communicating that proceed from different healthcare experiences.

Again, for this, drop comments or you can raise your hand if you want to share, but thinking about some of the things that he might see in a healthcare interaction, obviously outward prejudice was the first thing that came to mind in terms of gender, sexual orientation bias, racial bias, disability stigma... Those can manifest in so many different ways, and they can all come back to bite us (Laughs) It can be a very demoralizing, humiliating experience for lots of people to go to the doctor.

Which, I don't think everyone is always familiar with, and maybe doesn't think about in terms of --

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DR NEECEY HUDSON:
Sorry?

DR EMILY HOTEZ:
We lost you for a second. Can you say your last two sentences again?

DR NEECEY HUDSON:
Sorry! Then there is perception... I will pass it off to you because my internet is blinking. If you want to go from perception and action.

DR EMILY HOTEZ:
One thing I want to add also, as we are looking at this depiction of see, feel, communicate, think, do... Can you create this same graphic for the target population that you really want to affect change in?

If we are looking at the perception column, and trying to imagine: "what is Anthony feeling when they arrive at the doctor's office?" And you can generalize that to whoever you're specifically trying to reach to. Are they frustrated? Unheard? Overwhelmed?

What are some thoughts or cognition that may be coming to the fore, even before they step foot in the doctor's office? Maybe Anthony is thinking "I will never have a doctor who cares about" what are your patient's immediate first impressions were thoughts -- or thoughts? Mapping those out in something called empathy mapping, that can be really helpful in trying to understand your target populations experience.

Then, subsequently, you will have more success when trying to reach them, either through social media or in person, or however you are trying to communicate science communication to them.

Then, for action, how do they communicate? Do they communicate with hesitancy? Perhaps to voice their medical concerns. And what are they doing? Are they avoiding healthcare? Which is so often the case, and particularly damaging during the pandemic because we know that neurodivergent people, for example, another -- and other marginalized groups experience disparity. Are they avoiding the doctor?

Are they having a trauma response to a doctor's appointment?

Really thinking through some of these bubbles for your patient can be really helpful.

Are you back in action, Doctor Hudson?

DR NEECEY HUDSON:

Yes, I think so. (Static)

DR EMILY HOTEZ:

It sounds like you are underwater.

DR NEECEY HUDSON:

OK, next slide. Of course it does. (Laughs)

DR EMILY HOTEZ:

Now you're good! You

DR NEECEY HUDSON:

OK, good!

Some of the things I went over last time are different approaches to conceptualizing how people think through and process new health information. Among all of the models and theories that are out there, it is clear that they have all included in some way the concept that learning is dynamic and interactive with your environment.

In particular, you might begin with hearing about something and considering whatever the risk

or susceptibility is for that. In the case of the pandemic, obviously, that is COVID-19. Then, considering the susceptibility, how bad would it be? Am I predisposed were more likely to have -- or more likely to have adverse medical outcomes? Those things.

As we can see from the world around us, even a good understanding of that hasn't really been communicated to the populace, let's be clear. We are not exactly in the business right now of disease control. The centers or otherwise. (Laughs) It's just like, we are more so focused on politics, obviously. So there is so much of the power of this consideration of risk and susceptibility, has been lessened by the influence of misinformation and people's misguided beliefs about things that do not require belief. Because we have evidence for them.

So, that is something you also have to keep in the back of your mind because, like I said, these are full, whole people who have political influences, who have beliefs, whether they are based in misinformation, or personal experience, or whether they are heavily colored by traumatic experiences or distrust of healthcare system. All of these things exist at once, and we are seeing them play out from the individual level, all the way to societal policy management. Mismanagement.

DR EMILY HOTEZ:

Can you give an example before you go over each of those boxes? How Hood Medicine might, for example, address a question, doubts, hesitation, barrier, or social influence in a particular message that you crafted during the pandemic?

DR NEECEY HUDSON:

Yeah, for sure. When we think about people's ideas about the risk and susceptibility, we like to do a couple things. We really love to personify the virus. One of our favorite things to do is make infographics and cartoons and things with the virus having a grand old time at the party while we party, kind of thing.

We also like to... we think it's important because, as I just mentioned, there is so much of our interpersonal and societal influences that has distracted us from the battle of the species that this is. So we like to refocus back on the virus, and what it is giving out of the scenario, and what it is giving out of the consequence of our choices.

Then, in terms of specifically targeting ethnic communities and risk, or even disadvantaged or patient populations that are underserved, we like to frame our messaging in terms of those consequences and medical outcomes that we know these communities bear the brunt of. So we like to stress to people and bring first two minds that you know very well, based on your experiences, based on your distrust, based on the reason why you are so hesitant about vaccination that, if you get COVID, you are not going to get the quality of care that other people get. We are seeing it again and again, it is born out of all of the statistics full top click on Google, I promise you that a black and brown communities and disabled communities are bearing the

brunt of everything. Deaths, hospitalizations, infection rates -- infection rates, and are lagging behind in vaccinations for a myriad of reasons.

So we like to bring (Static) first to call, and first to mind, is the fact that if we get COVID, you will suffer. There will be a degree to which you will suffer just because of the lack you were given because of medical bias. Off the top, you're not gonna get access to the good drugs. (Laughs) Everything else. We know there is a disparity in (indiscernible) and therapeutics. The numbers are there, and every single person in the minority category, myself included, can regale you with stories, all night long, of their terrible experiences. So, we like to try and emphasize and say, "Just remember! You don't want to be the one in the ER because it's not going to be pretty."

There are things that we like to... and obviously that's more playing on a fear trope, maybe, in terms of anticipated outcomes and risks, but I think it's important because it is true. It's important to emphasize.

In terms of barriers and other things in hesitancy, I think, for example, with black communities, we have had a lot of success with graphics that give a little more detail with Tuskegee, the people have misconceptions about what the experiment actually was. In this case a lot of people presume that people were given as syphilis, and it was an experimental thing, but it was really that they recruited people who had a syphilis, and they refuse them treatments. And they let them, and their families, and their communities, for 30, 40 years before anything happens to curtail it and shut it down, as a human rights abuse.

So we like to highlight those things and send the message that we totally get it. You should be scared, you should be dubious, you should be dubious, we get it. We are right there with you. Our hunches are standing up to. But --

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SPEAKER:

I think we lost Doctor Hudson again.

DR NEECEY HUDSON:

Oh no! Can you hear me?

DR EMILY HOTEZ:

Yes, you are back.

DR NEECEY HUDSON:

I'm sorry.

So we just try to make sure that people understand that we get there distressed, but this is an existential threat, so...

DR EMILY HOTEZ:

Doctor Hudson, tell me if this assessment is correct, but... I think we are all rightfully hesitant about using fear in public health messaging, but to me when I am listening to you talk about some example posts, it doesn't sound as though you are necessarily leading with fear, as much as promoting access to information and being transparent about what the health disparities are, for example.

So, it sounds like it's kind of a mix of trying to appeal to emotion, but also to arm people with knowledge.

DR NEECEY HUDSON:

Yeah, for sure! I think we are all hypersensitive to fear mongering in this age, about many things, but I think we should monger fear because times are dark, you know? It's not that I'm using the trope as a trick, it's that I want my people to be afraid. Look at the numbers. It's not a joke. You know? So, to me, I think a little of that is necessary because the risk is so great and so often misunderstood because there is a lot of nuances to it, and there certainly a lot of nuance in terms of how we all manage it on an individual level, and how it mismanaged on a societal level.

OK. Last time we talked a little bit about barriers, which I think is also important to consider about your audience. And why is that? Because, hopefully you're halfway there now, but if we think about Anthony and the demographic that he comes from which, obviously, is an infographic (Static) --

I think all of these things, the risks, the barriers, the empathy, the emotional part, trying to get at the audience frame of mind, it's all important for you to start funneling into your own stream of consciousness, and trying to figure out what you would say to someone in that predicament? What would you say... what would you want someone would say to you if you were Anthony? You know what I mean? What would move you? What would resonate with you? Maybe you don't know the answer, but I promise you will get closer if you start to consider your audience on the micro level as well as the macro level. In thinking about all of those intersectional groups, and how they are--their experiences may be slightly nuanced to what you might perceive of the group as a whole.

So, these are some of the input that we got from people. Feel free to drop in the chat if you have other barriers that may have come up as we talked through Anthony's case about different barriers that he may face in terms of healthcare and lack of access.

Nicole says that (Reads) People promoting disinformation promote fear so well that there is hesitancy from those doing public health outreach to make it seem like we're doing the same.

For sure.

Then Brian likens this to (Reads) Emergency response messaging for disasters. It being hard to strike a balance.

Obviously --honestly that is why we try to use a lot of humor and colloquialism, vernacular, I know that it may seem like there is a propensity towards... maybe there would be a hesitancy there because you don't want to feel like you are creating things... let me back up.

I think from our perspective we feel authentically in some ways, part of our audiences, depending, because we have a diverse membership, and we have people who are in a lot of communities like black communities, queer communities, latinx communities, etc. for now, so far, a lot of the work we have done with Nero diversity and mental health, as well, we have a lot of stakeholders who help us fashion the boys.

That's the next thing I should probably say. (Laughs) You really should engage with communities, touch points, stakeholders to really get a proper reading on it needs and access barriers so that you have the right orientation when you start building your own framework for your audience.

So I'm kind of speaking from the sense that we feel like we are by and large within the community were messaging to, most of the time.

So, I'm not saying that I think you should all run out and make a bunch of slangy posters and everything (Laughs) It's not necessarily about that, in that sense, but I am saying we should maybe, like... try to expand our frame of mind in terms of developing messaging, and thinking about, not only vernacular cues, linguistics, and the way that people actually speak to each other, actually receive information, but using other devices like humor, and sarcasm sometimes; different, other language devices to break things up.

Because it can't always be doom and gloom. That's not what I'm saying. We do use humor a lot of the time because it is effective. It plants the seed, but it doesn't engender that kind of response from someone who might be super hesitant.

We've talked a little bit about what we need to communicate, but what were focused on a primarily as related to the pandemic, so obviously, the site comes part is all about the virus, the vaccines, prevention, all of the things that can help people equip themselves with the tools to keep themselves and their loved one safe.

There is always news that you probably have to share with your audience, whether it CDC guidelines or adverse events, or other EUA's that are on the horizon. So there will be things that are more like, maybe need to communicate or share articles, or take something from an article and try to break it down into simple terms for your audience. On infographic or something. Those will probably come pretty frequent, if any of you are doing the same work that we have been doing over the past two years.

I think it's important to have a good grasp on the science, and obviously whatever it is you're trying to communicate, so you can break it down in civil terms.

We like to do things like... sometimes we just talk about spit. Right? Why is that when you're not masked people can just spit in your face, the way air moves, basically break it down so people understand.

When we talk about mutations, we often use a paper as a metaphor. And a copy machine. That's the way the virus takes over yourselves, just keeps making copy errors, and that's an easier way for people to understand and grasp concepts around things that makes sense to them. It does mean you have to explain every single thing about it, depending on your audience.

We messaged to an LA audience that we presume doesn't have a medical background, we just want them to understand the what and why in a basic way. You can play with simple themes that convey complex ideas, and what's cool about that is there is always really cool graphics that you can use for things like paper and copy machines, and Swiss cheese, and stuff like that. Look up the Swiss cheese model when you get a chance, because it's great, and you should make your own version. (Laughs)

Then, obviously, for our communities, you also want to communicate aided services and advocacy's resources because you can never have enough. Again, herd immunity and other things we can do to take care of each other, and community care.

When we are starting to process all of that information about a particular topic or something that we think we have an audience in mind that were looking to share with, and even sometimes it's just broadly for us, like, let's say it's for an urban audience for lack of a better word, because not populated -- targeting any other subpopulations were just trying to message people that probably will respond to something a little more culturally tailored.

So, all of those inputs that we have talked about, the audience insights, the empathy mapping, all of the cultural and community and linguistic choices, and honestly, obviously (Laughs) There's a whole pop-culture zeitgeist to choose from. We all, by and large, have the same touch points in music and culture and all those things, so there is a lot to mine without getting to it down in the weeds with how to reach people from a cultural perspective.

Then, like I said, common individual themes that you can use to explain the scientific principles, and get your point across, that also lend themselves to really cool or funny graphical representations of that.

So we take all of these things, and we tended to have formats in our messaging, which I cannot spell, sorry about that. (Laughs) In our messaging and plans, and usually we will have a suite of messages that we put together about a certain topic. So, we might have once the deal with

health advocacy. That's when we were telling people what they need to do either to prevent disease, or scream for something, whatever the case may be. In this case, obviously, pandemic recommendations, and all the things that we needed to do to keep each other safe. The infographics that explain the science, and also some of the outcomes of COVID infection, we like to make that really clear.

Then we also have a subset that we might do that articulate social injustice themes, and healthcare, and particularly there is plenty to mine, in terms of the pandemic, and we like to highlight those things to remind people that if you are one of these people that means that this is the dismal statistic that we were working with, and it goes beyond everything. I think, again, that is what I am trying to (Static)... that Anthony is listed as having to good family, cool job and lives in a good neighborhood. It's good for Anthony, but so what. Because that doesn't mean anything for him when he steps inside an exam room. Then, he is the same black, queer, autistic person who's going to get the same biases and ill-treatment. I promise you. It doesn't matter who he is or what education he has. Or doesn't have. Or how much money he has. We'll get the same treatment. Google it.

In terms of engagement, we like to do things that just communicate allyship that helps us connect to our audiences will stop sometimes we just do what we call 'Greeting cards'. For example, in this case we may put out something that says "Saved the hood, get vaccinated." With a cool graphic. So it's not super busy with science info or infographic information, it's just little things that you can intersperse as you post that are cool or cute, or evocative of certain emotions to engage with your audience, and make them think that you have cool contents. That keeps them coming back, and it also, if they like it, it keeps you in the algorithm of their feet.

There are all kinds of other things that you can do. We do a lot of funny things, like I said, personifying the virus. As you really well. They don't serve any other purpose except to plant a lot of subliminal messages about how much fun COVID is having as a virus right now. While we deliberate masks.

ASAL BASTANI:

We have some questions in the chat.

DR NEECEY HUDSON:

Cool!

ASAL BASTANI:

Monica asks (Reads) How do you balance inclusive messaging strategy the government agency with a hard reality that the messenger shouldn't be a government agency? Do you have any examples that were done really well by either government agencies? Or government-funded organizations?

DR NEECEY HUDSON:

(Laughs) I wish I did.

I'll drop the Swiss cheese was--one... (Static) I think it was done in Australia by group. (Static) ... It made it really frustrating, for the pandemic, for us, with the naming of the big entities that you messaging for the pandemic. I guess that's what I was alluding to when I was saying that they all have a lot of... first of all, they'll use a lot of PR firms and marketing firms--. So they all kind of operate from that perception of health marketing where... the equivalent to me of having the black family on the Cheerios commercial? It's not very resonant with a lot of intersectional pieces of our population which do exist.

In some cases, it's not even any different, whatsoever. It was not differentiated, whatsoever, from the mainstream messaging. So, I would say it has been a very frustrating journey, probably for a lot of us, that have been doing this work. I feel like there is a lot of publication and studies and such on these disparities that exist, but there's not as much information on, I guess, ways to... how do I say this?

A lot of the government agencies, and the different larger groups that have been ascending a messaging, to me, there aren't a lot of good examples that I can point towards because, I think, from our experiences, and also from the products that we see around us, they have probably found a lot of difficulty with stopping on a dime and pivoting to try and cover a lot of populations that they purposely otherwise disenfranchise. As a business model.

So, it's been a frustrating push, tug, pull and tug...? I don't know what it's called. Navigating that in some of our (indiscernible) (Static)... I regret to inform you that I don't have any examples besides the Swiss cheese model, and so I will send that to you.

Everyone in the chat, literally well done. It's not particularly cultural tailored, but we did make her own culturally tailored version which you should also check out on our instep. (Laughs)

Then it says (Reads) Is it best to keep the different messaging format separate? Would combining them be too much of a class?

We totally do that as well. I guess this is just a conceptual framework. You can certainly combine, obviously, infographics with health advocacy for that we do that a lot, obviously. We will clean something and say, "You need to get vaccinated", that sort of thing. It doesn't to be discreetly separated, would you agree, Emily?

DR EMILY HOTEZ:

Agree. And sometimes you will want to speak to people with multiple, marginalized, intersecting identities, and then you might want to think about how you want to merge and combine and layer messaging on top of each other.

DR NEECEY HUDSON:

Thank you, Nicole for that. For dropping that note about Dr. Mona Hanna-Attisha. I'm going to look that up and see what they've got.

DR EMILY HOTEZ:

One of their questions was about if you could give an example of humor. So I am posting a link to one of hood medicines graphics that kind of personifies --

DR NEECEY HUDSON:

(Laughs) Which one is it?

DR EMILY HOTEZ:

It's "You're not the only one on spring break"

(Laughter)

DR NEECEY HUDSON:

(Laughs) Yeah...! At the beginning before we had vaccines and everything... (Laughs) We did do a lot with the Grim Reaper. It's less funny now that almost a million people died, and we are still not taking it seriously, but there were a lot in the beginning with the Grim Reaper which are hilarious. It's like the Grim Reaper hanging out with the virus. That is a little more bed,--morbid.

I would say our social media voice is somewhere between Wednesdays and Wednesday atoms if I had to put a pin on it.--Wednesday Adams. and Wendy's.

For public health organizations, for health departments, you will probably have more constraints than we do on our no-nonsense approach. That doesn't mean that you can't--

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DR NEECEY HUDSON:

-- There is trust in some ways, or starts to chip away at trust if they think you don't care.

Trying to get through the rest, I know were getting low on time.

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DR NEECEY HUDSON:

-- Depending what the demographic is you're interested in, try to answer the objections that you know is going to come from your audience in your messaging. Whether that is science info,

or putting risks in perspective, or using emotional cues, you are doing all of this work on the front end to try and understand their fears and hopes, and their objections, and their hesitations, so that you can answer them and assuage them and comfort them in what you are saying, so that, when you get the call to action, it's more evocative than it would've been if you had just completely ignored the fact that they had a distrust in the entire healthcare system. (Laughs)

Then, I will just leave you with our law of the land which is to keep it simple. Again, this isn't strict either, it's just a way of life. (Laughs) You know, whether that's three words, or three different slider panels, three bullets, or three graphics, I don't know... but humans have the attention span of a goldfish - Google that. And especially if you're targeting social media people who were scrolling, aesthetically keep it vibrant, then linguistically keep it brief. (Laughs) That's my biggest advice on that.

I think that might be it, so if there are any other questions or comments, please feel free to raise your hand.

Otherwise, Emily will drop a link to the wrapup (Static)... Once you do that, we can reach out to you to get you continuing education credits. Emily?

DR EMILY HOTEZ:

Yes, any questions? Or ideas? Or anything you have done that you think resonates with something we've talked about today?

As I mentioned before, think about some of the ways in which Doctor Hudson presented the strategy that she uses in order to develop public health messages, and can you replicate those graphics, tables, or frameworks, in order to reach we were trying to reach. Can you get in their shoes, and identify their barriers, their challenges, their hesitations, can you develop messages that are really speaking to your audience in a culturally tailored way? Can you challenge yourself to use three words, three panels, three bullets, through graphics? What do you think is most effective for your target audience? Hardest thing fear? Emotions?--narnessing -- Harnessing fear? Emotions? Knowledge and content? Try to take what we talk about in this webinar today, and repackaging for your purposes, and what you needed for. And please don't hesitate to reach out to us with any questions following the webinar. We are always happy to troubleshoot, and Doctor Hudson I'm sure is happy to consult on any infographics or content you're developing along the way.

Just a quick plug that we have two other workshops in our inclusive public health series, the next one is June 6, and AUCD will send a registration link for that. And please fill out the post feedback survey. That will help us to iteratively fine at this -- refine this series, for people who are serving neurodivergent communities during COVID and after COVID.

Anything else from Doctor Hudson? Or AUCD?

SPEAKER:

This is a staff from AUCD. Thank you, everyone for joining us. You can feel free to be in touch with me or Charisse. I believe Charisse's email was on the welcome, pre-email you should have received today. If you have any questions you can ask us, as far as how to register or when the next webinars are.

We want to thank you so much for attending, for being so active and lively in the chat. I think I'm going to stop the recording now.

DR EMILY HOTEZ:

Thank you, everyone! I hope to see you in June!

SPEAKER:

Thank you!

SPEAKER:

UCLA and Hood Medicine team, are we good to go and leave? Or do you want us to stand for anything?

SPEAKER:

We are good!

Live Captioning by AI-Media