Gender-Targeting Health Care Materials: A How-to Guide Using Military Sexual Trauma as an Example

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Abstract

The use of generic health care information resources is common practice within healthcare settings. However, generic health care information may lack in its ability to provide health information that is relevant to the unique needs of diverse patient populations. Research suggests health care information may be more effective if relevant sociocultural or health factors, such as gender, are taken into account. One way to increase the specificity of health information is through targeted health information materials, or material that is intended for a subset of the general population that is usually based on one demographic characteristic shared by the subgroup members. Research suggests gender-targeted health care materials may have positive effects on health outcomes; however, few resources are available to guide the creation of appropriate and effective targeted healthcare materials. The following paper provides a how-to guide on creating gender-targeted materials using military sexual trauma (MST) as an example. Four developmental steps are addressed: 1) assessment of need, 2) conceptualization and creation of materials, 3) collection and integration of feedback, and 4) distribution.

Key Words: gender-targeting, health care materials, health education, sexual trauma

Introduction

The dissemination of generic, one-size-fits-all health care information, usually in the form of printed or electronic educational materials, is common practice within healthcare settings. However, given the diversity of those who may need health care materials, a generic, one-size-fits-all approach may neglect to address the unique informational needs of specific populations, and materials may be more effective if relevant sociocultural (e.g., age, gender, ethnicity) or health factors (e.g., severity of illness) are taken into account. Kreuter,

Strecher, and Glassman (1999) identified three levels of specificity in health communication; generic, targeted, and tailored. Generic health care information consists of information about a certain health-related variable and is non-specific across sociocultural and health factor identifiers. An example of this is a diabetes informational brochure that describes the symptoms of diabetes without integrating information about sociocultural factors. Targeted information is intended for a subset of the general population and is usually based on demographic characteristics shared by the subgroup members (Kreuter et al., 1999). An example would be a diabetes informational brochure prioritized for adolescents with diabetes. The highest level of informational specificity is referred to as tailored information, which consists of information created for one specific person based on their unique personal characteristics (Kreuter et al., 1999). Tailored information is typically derived from assessment. Medical visit data can be used to tailor information to an individual by determining personal characteristics that may be related to outcomes. A tailored brochure for diabetes might specifically address the unique needs and risk factors of a patient based on the individual's blood sugar levels, physical activity, and eating habits (see Table 1 for further explanation of level of specificity).

Table 1 *Levels of Specificity in Health Communication*

Levels	Definition	Example
Generic	Information about a certain health-related variable that is non-specific across sociocultural and health factor identifiers	General eating disorders informational brochure
Targeted	Information is developed for a specific population and guided by the distinct demands and concerns of the population's members	Gender-specific eating disorders informational brochure
Tailored	Information intended to reach one specific person	Eating disorder brochure based on an individual's specific symptoms and behaviors

In a systematic review of the effects of printed educational materials in healthcare settings, Farmer et al. (2011) concluded that printed health materials have a small beneficial effect on positive behavior change. Farmer et al. also suggest that implementing printed healthcare materials is warranted when considering the relative ease of implementation in relation to the degree of positive outcomes. When considering the appropriate level of specificity needed in the creation of a particular health care material, feasibility and the needs of the population should be addressed. Whereas generic information may not always adequately address the important topics salient to population members due to variation within the population (e.g., age, culture, gender), the use of tailored materials may lack feasibility when implemented in large healthcare settings or in situations when larger audiences need to be reached. Thus, targeted health care information can be a pragmatic solution that reduces the need for the extensive resources required for individual tailoring while maintaining the ability to address information most salient to a specific population's health-related decisions and behaviors.

Prior research has provided evidence for both the feasibility and efficacy of targeted health information implementation in various healthcare settings (Kreuter & Haughton, 2005; Morgan, Fogel, Tyler, & Jones, 2010; Kissin, Tang, Campbell, Claus, & Orwin, 2014). For instance, educational materials regarding colorectal health targeted to African Americans were found to significantly increase colonoscopy rates as well as knowledge about colorectal cancer among this population when compared to generic materials (Morgan et al., 2010). Creating gender-targeted information has also been posited to be important for issues such as breast cancer (Iredale, Williams, Brain, France, & Gray, 2007; Thomas, 2010), childhood weight management (Simen-Kapeu & Veugelers, 2010), and physical activity (Bull, Kreuter, & Scharff, 1999).

There is a lack of consensus regarding an underlying framework by which targeted healthcare materials generate behavior change (Farmer et al., 2011). It may be that behavior change and treatment-seeking are explained, in part, by the theory of planned behavior (TPB; Ajzen, 1991). TPB posits that attitudes toward behavior, subjective norms, and perceived behavioral control collectively contribute to behavioral intention which, in turn, drives behavior. In the context of treatment-seeking, the identified prerequisite mechanisms of planned behavior can act as a guiding framework for the conceptualization and creation of targeted health care materials. For example, attitudes

toward a certain behavior, such as treatment-seeking, are conceptualized as the degree to which an individual believes the behavior will result in a positive or negative outcome. Treatment-seeking among individuals who hold pessimistic, fearful, or unrealistic views of treatment may be thwarted due to negative attitudes toward the treatment-seeking process (Godin & Kok, 1996). Similarly, subjective norms related to treatment-seeking may consist of the degree to which an individual believes that others similar him or herself seek treatment for health and wellness experiences. Perceived behavioral control related to treatment-seeking may encompass beliefs related to access to reliable and qualified healthcare professionals. In all such cases, targeting health care materials provides an opportunity to address and challenge such maladaptive beliefs and attitudes that may be widely held by a subgroup of the intended population (e.g., belief that seeking mental health care is a sign of weakness among male veterans).

In order for health care materials to be compelling and effective, they must be perceived as relevant to the recipient. Recipients of health care materials are more likely to respond to messages they believe represent their life experience and circumstances (Kreuter & Wray, 2003). According to Kreuter and Wray (2003), targeted messages that are congruent with cultural beliefs, level of literacy, and learning preference are likely to be perceived as relevant to recipients.

Gender-Targeting of Health Care Information

In the context of TPB, gender may act as a central mechanism that influences one's attitudes, subjective norms, and perceived control related to treatment-seeking (Sheeran, Norman, & Conner, 2001). Many health problems have relevant gender implications (Simen-Kapeu & Veugelers, 2010) and research suggests that providing gender-targeted information in public health interventions may increase their effectiveness (Brown & Summerbell, 2009). Given that information needs often vary by gender, gender-targeting may increase informational relevance, material use, and behavior change (Krieger, 2003).

Gender-targeting may be indicated in situations where gender impacts an individual's presentation of a health concern or attitudes and behaviors surrounding the issue (Krieger, 2003). Gender-related characteristics (e.g., differing symptom presentation) may influence a physician's likelihood of referral for diagnostic interventions and may lead to gender disparities (Krieger, 2003). Gender-targeting can take into account how gender roles and identities impact health outcomes by providing information that is salient to the needs of each gender. For example, men in a smoking cessation program were found to have more factors (e.g., concurrent or past substance use disorder) that affect their motivation for smoking cessation when compared to women (Okoli, Torchalla, Oliffe, & Bottorff, 2011).

Gender-targeting may also be warranted when a health condition is widely discrepant in its presentation among men and women. For example, breast cancer is a health issue primarily seen in women. Therefore the majority of breast cancer information resources are gender-targeted to the female experience of breast cancer (Thomas, 2010). However, the assumption that breast cancer is exclusive to women results in very few male-specific resources and a paucity of salient information in existing materials for male breast cancer patients (Iredale et al., 2007). In a qualitative study, Iredale et al. (2007) explored men's opinions on existing breast cancer resources. Overall, men felt alienated by the explicitly female-specific information and described it as inadequate and occasionally irrelevant. All men in the sample expressed a desire for male-specific information. Given that individuals require salient and relevant information to reduce distress and facilitate decision-making (Luker et al., 1995), addressing the gender-specific physical and psychosocial implications of illness may improve the utility of health education materials.

Gender may significantly influence one's presentation and experience of an illness in addition to attitudes about treatment-seeking. For example, military sexual trauma (MST), defined as threatening sexual harassment or sexual assault that occurred during a veteran's military service (U.S. Code, Title 38 § 1720D), may elicit gender-specific reactions (Turchik, McLean, Rafie, Hoyt, Rosen, & Kimerling, 2013, Turchik, Rafie, Rosen, & Kimerling, 2014). While male MST survivors may struggle with issues surrounding masculinity, sexuality, and beliefs that men are less affected by sexual trauma, women may have difficulty seeking MST treatment as a result of barriers related to stigma and personal belief in rape myths (Turchik et al., 2013, Turchik, Bucossi, & Kimerling, 2014). These issues may keep male and female veterans from seeking treatment related to MST and suggest that gender-targeted informational outreach may be needed to increase awareness and access to MST-related care (Turchik et al., 2013).

Existing literature suggests individuals may prefer gender-targeted health information (Iredale et al., 2007; Turchik et al., 2013, 2014) and the availability of gender-targeted materials and interventions may increase positive outcomes in some circumstances. However, despite indications that gender-targeting is effective, very few resources exist to help health care providers in creating targeted materials. The purpose of the current article is to provide a guide to inform the

development of gender-targeted health education materials. Based on prior research, it is believed that gender-targeting can produce more effective health education materials for various health topics including sexual trauma, physical activity, and breast cancer (Bull et al., 1999; Iredale et al., 2007; Turchik et al., 2013). Further, research has demonstrated that more than half of current printed health materials may not be suitable for the populations they are intended (Shieh & Hosei, 2008) suggesting the need for more instructional guides to create materials that are accessible and suitable for the patient population. This guide intends to provide assistance in the development of such materials by sharing specific examples used by Turchik, Rafie et al. (2014) during the creation of gender-targeted resources for MST. These step-by-step recommendations were developed and influenced by the Kreuter and Wray (2003) communications strategies for the enhancement of information relevance and TPB (Ajzen, 1991) constructs of behavior change with the aim to provide a comprehensive, systematic, and user-friendly approach to gender-targeting health information.

Steps to Developing Gender-Targeted Health Information

Four steps to creating gender-targeted health information are outlined in detail below (see Table 2 for an overview of the steps).

Table 2 *Steps to Developing Gender-Targeted Health Information*

Step	Description	Example from Turchik et al. (2013; 2014)
Step 1	Assess the benefit of gender-targeting information for your population	Benefits of gender-targeting were assessed by consulting MST experts and interviewing veterans
Step 2	Conceptualize and create your materials	Printed gender-targeted brochures were developed to address gender-specific problems related to MST
Step 3	Continuous loop of seeking formal and/or informal feedback and implement revisions as necessary	Veterans who had experienced MST provided feedback on the gender-targeted MST brochures and this information was used to revise the material
Step 4	Distribute the materials	A electronic brochure was made available for VA employees to access, print, and distribute to patients

These steps were influenced by the enhancing information relevance communication strategies outlined by Kreuter and Wray (2003). These strategies, such as consideration of a person's circumstances, life experience, and predisposition to behavior change, are designed to help motivate patients to process health messages by making the information personally relevant.

Step 1: Assess the Need for Targeting

It is important to critically assess the potential benefit of targeting for your population prior to the creation process. In regards to gender-targeting, consideration of how gender influences the targeted behavior (e.g., access to care, comfort regarding care offered or received, treatment adherence, treatment response, or satisfaction) is key in order to improve relevance. See Krieger (2003) for a tutorial on understanding the impact of gender on health outcomes. To determine if gender is associated with the desired behavior change in a population, explore the literature and consult with colleagues, clinicians, and patients. One could also administer informal surveys, conduct focus groups, or integrate questions about gender-targeting into existing program evaluations to better answer this question if there are reasons to believe that gender differences may be present (see Table 3 for further guidance on assessing the need for targeting).

Table 3 *Is Targeting Warranted?*

Questions to Consider	Rationale
Is there variation within the population?	If a population is homogeneous, there is no variable to target
Is there a discrete or specific characteristic that can be targeted? (e.g. gender, age, ethnicity, geographic location).	Targeting information requires identifying a specific variable that accounts for differences within a population
Does variation affect access to care, comfort, treatment adherence, treatment response, or patient satisfaction?	Targeting will not be effective if the variation in a population does not account for differences among these factors
Could targeting this characteristic cause undo harm, marginalization, or offense?	Targeting certain characteristics can lead to a perceived stigmatization or discrimination among that population
Is there access to resources needed to create targeted materials? (e.g. administrative support, financial resources)	The project must be feasible within the setting that it is being created
Is there a means of distribution and institutional support or restraints?	Targeting is practical only if distribution to the targeted population is possible

Example. *Turchik et al. (2013) began assessing the need for gender-targeting by first consulting stakeholders. This included discussions with clinicians and colleagues experienced in working with veterans who understood the culture of treatment-seeking within the U.S. VA healthcare system. The team also conducted qualitative interviews with veterans to assess their opinions on how gender was impacting their experiences of MST-related treatment. Existing research also demonstrated that there were significant differences in the utilization of health care related to MST for male and female veterans (Turchik, Pavao, Hyun, Mark, & Kimerling, 2012), suggesting that gender may influence treatment-seeking. After numerous discussions with clinicians and veterans and an extensive literature review, the team concluded that gender-targeting might be appropriate when addressing MST-related treatment.*

Step 2: Conceptualize and Create Gender-Targeted Materials

When conceptualizing targeted materials, it is important to consider several factors including: who will receive the materials, content of the materials, and how and where the information will be accessed. Each decision related to the materials requires grounding in both empirical evidence and the input of the various stakeholders, with specific emphasis on input from the intended population.

Identify who will receive the information. In order to identify who will receive the materials, first consider the rationale behind targeting to one gender or creating specific materials for each gender. Different settings elicit different answers to this question. A women's clinic may only necessitate female-specific materials whereas a community medical care setting may benefit from providing materials that uniquely address concerns for each gender. It is also important to consider if providers, patients, caregivers, or multiple groups will use the materials.

Identify the content of your materials. As expected, greater levels of customization generally result in greater perceived relevance to the target patient (Kreuter et al., 2003). Therefore, it is encouraged that materials demonstrate salience to the targeted factor (i.e., gender) in multiple dimensions. For example, a gender-targeted brochure could address multiple TPB components such as a) attitudes toward relevant factors such as health care and treatment-seeking, b) thoughts and beliefs related to behavioral norms, and c) the degree to which individuals believe they have access to care and perceived ability to act on intended behaviors.

A potential mistake in gender-targeting is assuming that the use of gendered pronouns is sufficient to deem materials gender-targeted (e.g., changing he/him to she/her). Successful gender-targeted materials

may include gender-specific images, common beliefs held by those who prescribe to the gender roles (e.g., belief that treatment-seeking is related to weakness among men), and acknowledgement of unique characteristics and issues that may be associated with a particular gender (e.g., availability of childcare in materials aimed at a group of young mothers). The results of a literature review and needs assessment can be used to identify what information the targeted materials will include. This process will require continued consultation with stakeholders to determine the necessity of targeting and to identify the key gendered factors that may be influencing the behavior of the population. One should also consider the intended goal of the materials. Materials that will be used to increase treatment-seeking will look different than those aimed at increasing patient comfort with health care providers. A treatment-seeking brochure may include helpful phone numbers and resources while materials focused on increasing patient comfort may include encouraging testimonials.

Whereas gender targeting may be the focus, creators should not neglect to ensure that the materials make use of guidelines for creating high-quality health education materials. Numerous studies and guidelines have identified the elements of suitable education materials that include factors such as visual appeal, interest, organization, writing style, language and structure, content, and instructiveness (Johansson et al, 2004; Meade & Smith, 1991; Wilson & Williams, 2003). Guidelines have also been given by some organizations and individuals, including the Area Health Education Center Assessment Checklist (Wilson & Williams, 2003) and the Suitability of Assessment Materials (Doak et al., 1996).

Identify how information will be presented. The success of targeted materials is largely determined by how and where the information will be presented to the population. There are various formats in which to present gender-targeted information including brochures, posters, and digital or print formats, and many different locations where the information may be presented including being provided by the clinician, left in the waiting room, or made available on an agency's website. Regardless of the format, always consider reading level, language barriers, and any limitations of the priority population (, Shieh & Hosei, 2008). In a study by Shieh & Hosei (2008) assessing the readability and suitability of printed materials, 53% to 83% of printed materials were deemed to be at or above a 9th grade reading level, which is significantly higher than the average reading level of the United States population. In order for health information materials to be effective, they must be accessible to a wide range of health literacy levels. For more information on the technical aspects of creating health education materials, including determining readability for a range of literacy levels, see Centers for Disease Control and Prevention's Simply Put guide (2009). It is also important to consider any local facility regulations including inclusion of logos, how information can be presented and where, and any necessary supervisor or institutional approvals that may be needed.

Material format is influenced by the goal of the materials. If the goal is to increase treatment-seeking, it may be most effective to make the materials available online to encourage patients to return to the clinic. If the goal is to initiate a discussion with the provider, printed versions that providers can distribute to patients or leave in the waiting room may be indicated. Once a format is chosen, it is important to ensure access to the appropriate tools and resources necessary to create the desired materials. Microsoft Publisher, Microsoft Word, and Adobe Photoshop are all viable options to create materials.

Example. *Turchik et al. (2013) and Turchik, Rafie et al. (2014), developed a digital printable gender-targeted psychoeducational brochure using Microsoft Publisher that allowed providers to print copies for their waiting rooms or for individual patients as needed. In order to increase the perceived information relevance, each brochure addressed the attitudes and beliefs determined by previous literature to be the most salient to each gender in relation to MST. The men's brochure included concerns about sexuality, masculinity, and unintended sexual arousal whereas the women's brochure addressed concerns about seeking care in a male-dominated environment and gender preference of provider. Both brochures included brief MST survivor testimonials that highlighted the most common concerns of MST survivors and information on how to access MST-related care. Knowing each gender-related factor had varying salience to each individual, Turchik et al. included multiple themes and types of information in an attempt to increase the relevance for a larger percentage of patients.*

Step 3: Seek Feedback from Population

Once the conceptual framework has been adequately addressed and the materials have been created, the next step is to seek feedback regarding the informational materials. Appropriate feedback can be obtained either through formal research (e.g., survey research, semi-structured interviews, focus groups) or informally through conversations with members of the priority population or identified representatives. It should be noted that, although a formal method of gathering

feedback through surveys and structured studies is ideal in theory, the method of gathering feedback that is used should be guided by the knowledge and resources that are available within the setting that the materials are being created.

Examples of suitable ways to gather informal feedback include distributing the material to colleagues and asking for feedback or disseminating the material in a classroom setting and eliciting student feedback. Feedback from patients, caregivers, relevant advocacy group members, and/or health care providers is highly desirable, although care must be taken to insure that gathering feedback from these populations is not done in a coercive way, and that special consideration is taken before asking current patients. Consultation with a research board or institutional review board may be appropriate prior to seeking feedback from vulnerable populations.

If more systematic or in-depth feedback is desired, formal research methodology can be used. Qualitative studies can be used to address whether the materials meet the unique informational needs of the population. If conducting a formal research project is not feasible, another option is to add questions for feedback to a research project currently being conducted with the same population. Feedback from the population should then be consolidated and used to revise the materials. If major revisions have been made to the materials, it may be advisable to seek further feedback prior to distribution to ensure that subsequent problems have not emerged due to the changes.

Example. *After creating a gender-targeted MST brochure, Turchik et al. sought institutional research approval and then obtained feedback from male (n = 20) and female (n = 9) veterans who had experienced MST (Turchik et al., 2013, Turchik, Rafie et al., 2014). Using a semi-structured interview, the research team found that male and female veterans preferred a gender-targeted brochure to a gender-neutral MST brochure, describing it as more encouraging of treatment-seeking and more helpful overall.*

Furthermore, a mailed survey was used to examine male veterans' responses to a gender-neutral and a gender-targeted brochure. It assessed a) if the information addressed an issue that was important to male veterans, b) if the brochure would encourage treatment-seeking, and c) the overall rating of the brochure using a 1-5 scale (Turchik, Rafie et al., 2014). An open textbox was also provided where veterans could provide any feedback or comments on the MST material. Using this data, the research team found that veterans rated the gender-targeted brochure higher on all three items and then used feedback responses to guide revisions of the brochure. Following this, it was concluded that continuing to the distribution phase was warranted.

Step 4: Distribution

Different populations may have unique needs concerning the accessibility and usability of health care information. Thus, consideration of the population and the targeting variable should guide the distribution process. Health care information can be distributed either as printed materials (e.g., booklets, posters, pamphlets, or brochures) or electronically through websites, computer modules, and email. The benefit of printed health care information is the ease in which they can be created with limited resources and technical knowledge. Because printed materials may be left in a public space, printed health care information may reach individuals who are not actively seeking that particular information and may better serve populations with less access to Internet or computer use.

In contrast, the benefits of electronic health care information include its adaptability and ease of access within certain populations. Health care information presented online has the ability to reach individuals that do not have access to settings where printed information is commonly obtained. Electronic information can also be modified or updated more easily as new information becomes available and more specific target variables can be used without the need to provide multiple versions of informational material onsite. A study by Noar, Benac, and Harris, (2007) implemented electronic screening measures that automatically generated targeted information based on patients' responses to a one-item ethnicity screener. Once patients identified their ethnicity, targeted information was automatically generated based on the patient's response. A similar protocol could be implemented using gender in place of ethnicity.

A significant consideration in the distribution of health care information is how to optimize access to the materials. Some targeting variables such as gender may require different distribution strategies as men and women may face different difficulties or preferences in access to health care materials. For example, patients may not feel comfortable accessing sexual assault information in public places so providing access to these materials in private places (e.g., bathroom stalls) may be beneficial. Some distribution strategies may lead to certain problems that would need to be considered. For example, if male and female targeted materials are displayed in a waiting room, one of them may run out, leading to a situation where only one gender has access to their respected material and may leave members of

the other gender feeling marginalized. It should be noted that there is no gold standard distribution process, and that distribution and its potential problems should be guided by what seems most practical for the specific population and setting.

Once the materials have been distributed, it is important to continue to gather feedback from the population and address any concerns that may arise. Large-scale distribution of the health care material may reveal problem areas that were not addressed when feedback was first obtained. Similarly, it is important to address and incorporate any changes in healthcare policy or new research findings that pertain to the targeted population.

> **Example**. *Once the MST brochures were completed and feedback was incorporated, printed materials were placed in waiting rooms for patients to access directly. Turchik, Rafie et al. (2014) also created a .pdf version of the brochure and made it available on the VA Microsoft SharePoint site where VA employees nationally could access, print, and distribute the information to patients. This was done so that providers could choose how to distribute and provide the best access to the information to their patients. The VA SharePoint site also included Dr. Turchik's contact information for providers to give feedback and suggest future changes.*

Discussion

The purpose of the current article was to provide an easily accessible guide to inform the development of gender-targeted health education materials. Previous research has suggested the level of specificity and salience of information can have an effect on patient motivation for behavior change (Kreuter & Wray, 2003). Therefore, health education should strive to achieve personal relevance for patients to attain thoughtful processing of information and enduring behavior change. While individual tailoring is likely the most impactful in changing patients' attitudes or behaviors, targeting represents a compromise between nonspecific generic information and the highly specific information found in tailored healthcare information (Kreuter & Wray, 2003). Studies have demonstrated both patients' desire for targeted health materials (Iredale et al., 2007; Turchik, Rafie et al., 2014) and the effectiveness of such materials (Bull et al., 1999; Morgan et al., 2010); however, health education materials are often unavailable or unsuitable for the intended population (Shieh & Hosei, 2008). The apparent dearth of adequate health education materials suggests a lack of provider knowledge regarding the creation of effective health education materials.

Research involving the investigation of gender-targeting is in its infancy. In addition to healthcare settings, the need for gender-targeted information has been suggested in other settings such as in the juvenile justice system (Bloom & Covington, 1998; Goodkind, 2005) and in schools (DiDonato, Johnson, & Reisslein, 2014). While studies may suggest a positive response to targeted materials more broadly (Bull et al., 1999; Kreuter et al., 1999; Kreuter et al., 2003), the impact of gender-targeting on treatment-seeking is still unclear. Initial studies do suggest gender-targeted information may be received positively by male and female patients (Turchik et al., 2013, Turchik, Rafie et al., 2014) and is associated with decreased stereotypes and increased positive outcomes in school settings (DiDonato et al., 2014).

The current article outlined four general steps in the development of successful gender-targeted health materials: assessment, conceptualization and creation, feedback, and distribution. As previously discussed, a thorough assessment of need provides the foundation for the later stages of material development as well as the rationale for such materials. This first step is followed by the conceptualization and creation of the materials, which should be informed by the informational needs of the population, the intended audience, and how and where the information will be accessed. Both formal and informal processes including consultation with stakeholders and review of the relevant literature should inform the conceptualization and creation of the materials. Following creation, feedback regarding the content and design of the materials should be gathered and incorporated. Similarly to the assessment of need, feedback may be gathered through informal or formal processes such as focus groups, surveys, or more comprehensive research studies. Lastly, successful dissemination of the materials includes consideration of the unique needs of the targeted population and the institutional resources available. Overall, consultation, openness to feedback, and flexibility are crucial when creating materials that will be widely distributed.

The goal of this paper was to provide useful examples of gender-targeting health information materials; however, each setting and population may have different needs, expectations, and obstacles. Flexibility and careful consideration of the nuances of a setting are critical to a positive receipt of targeted materials. It is important to consider the limited focus that targeting has on demographic facets that may vary in relevance from person-to-person. Tailoring information allows health care materials to be as salient to the person as possible and address the interactions

between identities, which has been found to increase the perceived credibility and relevance of information for patients (Skinner, Campbell, Rimer, Curry, & Prochaska, 1999). For example, targeting to gender alone may reduce the relevance for an elderly African American female versus an adolescent Hispanic female despite the fact they share the same gender. Tailoring allows one to account for the interactions between identities and address an individual's unique needs and concerns. However, tailoring information is not always feasible. In these instances, utilizing targeted health care information can be a viable alternative to address the hypothesized common factor influencing health behaviors. As with all steps in creating targeted health care materials, identifying the influential common factor requires consultation with experts and other stakeholders including patients. When done right, targeted health care information can provide salient and useful information. When done wrong, materials can be ineffective and perceived as offensive, and may come across as stereotypical rather than sensitive. Targeted materials may be a catalyst to facilitate broader conversations between patients and providers about the impact of gender and other characteristics in settings' policies and practices. For instance, the presence of gender-targeted materials may demonstrate to patients that providers are open to discussing patients' struggles related to gender roles or gender specific issues such as the impact of masculinity on treatment-seeking. Exhibiting sensitivity to the unique needs of patient populations through gender-targeted materials can increase patients' confidence in an organization and demonstrate their provider is attuned to their needs.

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