



# Perspectives on Health Communication from Selected Sub-Saharan African Contexts

Elizabeth Lubinga, Konosang Sobane & Karabo Sitbo-Kaunda (Eds)







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# Contents

Introduction .....	i
<i>Elizabeth Lubinga</i>	
<b>Chapter 1:</b> The changing practice of health communication through digitalisation across sub-Saharan Africa .....	1
<i>Karabo Sitto-Kaunda</i>	
<b>Chapter 2:</b> A Whole-of-Society (WoS) Approach to Health Crisis Communication in Ethiopia Intersecting Indigenous, Traditional, Social and Interpersonal Media .....	25
<i>Tesfaye Alemayehu</i>	
<b>Chapter 3:</b> Decolonising Health Communication Strategies: The Inclusion of Traditional Healers from Sub-Saharan Africa into Multi-Sectoral Health Crisis Communication Interventions .....	67
<i>Elizabeth Lubinga and Aniekie Motloutsi</i>	
<b>Chapter 4:</b> Science and Health Journalists in the Health Communication Continuum: Working towards Improved Skills and Capacities in South Africa and Namibia .....	95
<i>Nkosinethando Mpofo</i>	
<b>Chapter 5:</b> Towards a Health-Promoting Campus: Institutional Complexities in Communicating Health Information in Uganda's Higher Education Sector .....	129
<i>Aisha Nakiwala Sembatya</i>	

<b>Chapter 6:</b> Multilingual communication, Multimodality and Multivocality as Enablers of Information Access: Teenage Pregnancy Interventions in South Africa and Lesotho .....	161
<i>Konosoang Sobane</i>	
<b>Chapter 7:</b> Indigenous Language Use in Knowledge Dissemination in South Africa During the COVID-19 Pandemic .....	187
<i>Mmakwena Molala</i>	
<b>Chapter 8:</b> Communicating HIV/AIDS Biomedical Prevention Strategies Amongst Young Urban Women: Use of Pre-Exposure Prophylaxis (PrEP) in Kenya and Uganda .....	209
<i>Denish Otieno</i>	
<b>Chapter 9:</b> The Need for Effective Health Communication Systems in Lesotho .....	225
<i>Rethabile Malibo</i>	
<b>Chapter 10:</b> A Comparative Review of Health Communication Research in West Africa and Other Sub-Saharan African Countries (2018–2022) .....	269
<i>Ijeoma Ajaero</i>	
Author Bios .....	297



# Introduction

Elizabeth Lubinga 

In Africa, health communication persists as an instrumental factor in the quest for effective healthcare service delivery for vulnerable African populations. The vulnerability of African populations is best understood through multiple lenses. For instance, from a socio-economic perspective, this vulnerability can be examined within the context of a continent made up of several resource-constrained countries, and the important role that communication plays. Many sub-Saharan countries are highly prone to numerous interdependent socio-economic ills such as the terrible twin problems of poverty and unemployment; interminable social inequalities; a never-ending heavy burden of disease and the inequitable quality of healthcare service provision (de Villiers, 2021). The use of communication for health becomes particularly relevant in these contexts, where such disparities in access to healthcare are rife, and communication becomes a crucial tool that continuously contributes to bridging health inequality gaps amongst other uses. Firstly, health communication fills an important information gap in contexts that are rife with social ills. Interdependence and intersectionality of social ills as well as their detrimental effects on sub-Saharan African populations is underscored by, for instance, the heavy burden of disease that is compounded by poverty and unemployment.

Secondly, the pivotal role of health communication should additionally be approached through the lens of several enduring and intermittent epidemics of communicable diseases, as well as non-communicable and other diseases that plague sub-Saharan Africa. Containment requires constant communication during the various stages of disease life cycle. As Gray (2024) reminisces, the COVID-19 outbreak in 2019 offset a global information crisis, birthing a complex tri-information disorder consisting of disinformation, misinformation and mal-information. The outbreak unearthed multitudinous roles for health communication which from a health agent perspective became



vital to allayment of public fears, public assurance about the actions that health agents were taking, mitigation of rumours and disinformation, education about preventative solutions as well as recovery procedures (Gray, 2024).

Health communication becomes the tool for strategic dissemination of critical health information with the goal of changing behaviour (Schiavo, 2013). Epidemics typically occur in excess of disease that is expected in particular communities at a specific time. The World Health Organization refers to outbreaks of epidemic-prone diseases that emerge and re-emerge as the greatest threats to public health (WHO, 2024). Take for example, the Ebola virus disease (EVD or Ebola) epidemic that broke out in West Africa from 2014 to 2016, causing over 28,000 reported cases and over 11,300 deaths in Guinea, Liberia and Sierra Leone (CDC, 2019). It was the largest recorded Ebola outbreak in sub-Saharan Africa (WHO, 2023), even though for decades the disease has been endemic to the continent with the first recorded cases reported in 1976 in Sudan and the Democratic Republic of Congo (then Zaire). With human immunodeficiency virus (HIV) / acquired immunodeficiency syndrome (AIDS), it is believed that HIV prevalence amongst human populations may date back to the 1930s (Knox, 2006). Sub-Saharan Africa, the subject of study for this book, has been considered to be the epicentre of HIV/AIDS even though it contains only 11 per cent of the global population. For instance, whereas the global adult HIV prevalence in 2002 was 1.2 per cent, in sub-Saharan Africa it was 9.0 per cent. And out of 40 million people living with AIDS, 28.5 percent of them were based in the African “AIDS Belt”, made up of eastern and southern African countries, specifically Djibouti, Ethiopia, Uganda, Kenya, Tanzania, Rwanda, Burundi, Mozambique, Malawi, Zambia, Zimbabwe, Namibia, Botswana, Swaziland, Lesotho, and South Africa (Goliber, 2002).

## **Value of health communication for sub-Saharan Africa**

Thirdly, from a viewpoint of communicative value to health, these enduring sub-Saharan epidemics that emerge and re-emerge,

exhibiting intermittent episodes, require communication at various stages. Gray (2024) posits that honest and meaningful communication is at the apex of managing pandemics. It can be argued that this statement is applicable to epidemics and other disease scenarios. From a health professional angle, communication is critical for creating public awareness and buy-in as well as adaptation of preventive behavioural measures with the advent of an epidemic. Additional communication will include providing advice about such preventive measures. During the progression of the epidemic, communication through provision of timely and regular information is crucial and adapting different approaches as new knowledge about the health problem emerges (Gray, 2024).

Health communication is versatile, because it is often tailored to suit multiple but specific needs during various stages of health problems. In terms of its functions, health communication serves to inform, educate, and may simultaneously entertain and educate (edutainment) as well as persuade targeted audiences for behaviour change. When a new disease emerges or re-emerges, in-depth communication is indispensable towards creating awareness about the nature of the disease; where to source treatment; preventative behaviour measures and resources; change pre-existent socio-cultural attitudes, beliefs and perceptions by individuals, communities or society that may negate preventative measures or treatment uptake. During subsequent stages, communication entails ensuring treatment compliance; servicing and maintaining supporting structures for infected as well as affected individuals within homes, communities and societies such as family, community, healthcare professionals, amongst others. Towards the declining stages, public apathy to compliance becomes ubiquitous and may negate previous communicative strides made to contain health problems.

Communication of new treatments remains constant throughout the life cycle of diseases. Consider the fact that HIV/AIDS became highly visible in sub-Saharan Africa during the 1980s, yet approval of effective treatments such as Truvada® only happened in 2012 and HIV pre-exposure prophylaxis (PrEP) took place in 2022, approximately three decades later. There is

a need to constantly conceptualise and disseminate tailored and audience-specific communication, monitor (UNAIDS, 2023) and evaluate the effects of communication on attitudes, perceptions and behaviour before, during and after health problems escalate and for general communicable and non-communicable diseases.

### **Other factors that necessitate health communication in sub-Saharan Africa**

Apart from the already-mentioned socio-economic challenges, there are cultural and systemic imperatives that necessitate health communication in sub-Saharan Africa. The continent is multilingual, which demands a focus on health communication as an essential facilitator of access to health services. The recent Coronavirus disease 2019 (COVID-19) pandemic further illuminated the infrastructural and systemic complexities of access to healthcare in Africa and demonstrated the value of focusing on strengthening health communication systems as components of a preventative and mitigating care process. Equally important is the effective use of digital technologies to ensure that innovative health communication systems are developed, while indigenous and contemporary knowledge systems should also be incorporated to provide contextualised and culturally sensitive information.

### **Scholarship of health communication**

Health communication is pivotal to various health processes. Key to this book is the acknowledgement that the scientific study of health communication is recent. Having emerged during the 1970s (Thompson, 2014), it has distinguished itself as a distinct scholarly field that achieves more than mere dissemination of information through combining scientific research with communication. The scholarship of health communication is interdisciplinary, encompassing informatics and big data, psychology, journalism, health promotion as well as health education amongst other disciplines, with the latter two involving individual, group, community or societal communication using interventions. Despite this widely acknowledged significance

of health communication as an essential component of a comprehensive healthcare delivery process, a paucity of books that specifically engage and amalgamate scholarship on context-specific perspectives of health-related communication in Africa exists. Whereas the scientific study of health communication is fairly recent, it holds great potential to develop exponentially.

Health communication distinctively represents individual, group, community and societal well-being globally. By nature, health communication, as with all other communication processes begins with an individual communicator or organisation that formulates a message, through a medium of communication to an audience. Of importance to note, is that health communication occurs in various contexts; intrapersonal, interpersonal, small group, organisational, mass, digital, social media, and public contexts (Burger, 2024). Furthermore, health communication targets varying recipients through its various contexts. As Schiavo (2013) notes, health communication plays an important role of influencing, supporting, and empowering individuals (intrapersonal), communities (small group / mass / digital / social media or public), healthcare professionals (interpersonal / small group), policymakers (small group / mass), or special groups, to adopt and sustain a behaviour or a social, organisational, and policy change.

## **Convergence between digital and “whole of society” health communication**

The use of digital technologies for health is not new to the sub-Saharan African context. The multitude of digital technologies used for health in sub-Saharan Africa ranges from digitised health, mHealth, telemedicine, e-Health, online health services, virtual hospitals or infomedicine (Lupton, 2018). Furthermore, at a personal level, even though globally, digital technologies and artificial intelligence (AI) are revolutionising the way individuals receive personalised health information, some of these are not accessible to many sub-Saharan populations. An ever-growing plethora of wellness gadgets is increasingly facilitating micro-engagements through for instance, AI-smart wearables such

as wrist wearables using smart watches and ring wearables. Gadgets such as pebble-shaped Withings U-scanners provide the benefits of at-home urine laboratories providing daily health readings, portable ECG (electrocardiogram) monitors, smart inhalers, UV (ultraviolet) trackers, smart water bottles that track water intake and providing reminders (Ng'aali, 2023) are not accessible to most people in sub-Saharan South Africa. The first chapter of this book debates the paradoxes of using digital health. Inasmuch as information increases with advancements in digital technology, sub-Saharan Africa's Internet penetration rate remains pervasively slower than the global average, with those in need of healthcare excluded due to the digital divide. The digital divide was theoretically proposed by van Dijk (2005) about how social stratification and Internet access excludes the "have-nots" and has morphed into current debates that there are several dynamic digital divides in existence (van Dijk, 2020). The digital health divide negatively affects mostly poor people who do not have or cannot afford access to the Internet, lack digital literacy and are excluded from healthcare that is accessible to rich people, amplifying health inequities (Timmermans and Kaufman, 2020).

In **Chapter One** Karabo Sitto-Kaunda outlines as well as critiques the inevitability and importance of digitisation in health communication amongst various sub-Saharan African contexts. It highlights the many opportunities for digital health and communication, the influence of digital communication technologies on health practices, how these technologies have been used to democratise access to health information, as well as the key benefits and challenges of digital health communication.

Through a reflection on COVID-19 health communication in Ethiopia, in **Chapter Two** Tesfaye Alemayehu discusses how Ethiopia, in East Africa, employed "Whole-of-Society" health communication approaches that amalgamated indigenous, mass, social and interpersonal media amongst others for health crisis communication. The chapter examines media and communication strategies employed in Ethiopia during the COVID-19 outbreak to minimise the disease's spread and ensure public response. Using the theory of innovation diffusion, the chapter briefly discusses the relationship between health

policy and the interventions that were implemented, while exploring the roles of opinion leaders and change agents in communicating health.

### **Interpersonal and mass communication for health**

Traditional healers play an important role as health communicators in sub-Saharan Africa. Using in-person and increasingly online interactions, they have not been widely acknowledged for their indigenous health skills as practitioners. Elizabeth Lubinga and Aniekie Motloutsi posit in **Chapter Three**, that during times of epidemics and pandemics, many Africans revert to traditional healers even though health-seeking often involves parallel use of Western and traditional medicine with the latter sought first. Utilising decoloniality, Africanisation and a culture-centred approach. The chapter contends that normative health-seeking behaviour of many Africans should provide policymakers with insight into inclusion of traditional healers as important stakeholders to partner with when crafting effective health communication strategies during epidemics and pandemics. Equivalently, Nkosinotando Mpofo in **Chapter Four** explores the systemic and capacity challenges of science and health reporters in Namibia and South Africa by specifically delving into the experiences of these journalists who reported on COVID-19, their challenges and their capacity needs for effective reporting on science issues. Using the hierarchical model of influence, it argues that understanding the capacity and capability needs of these journalists will contribute towards skills enhancement and more effective science and health journalism.

### **The multifarious nature of health communication: multivocality and multilingualism**

Due to the multifarious nature of health communication, through **Chapter Five** Aisha Nakiwala Sembatya focuses on health communication in an organisational context by examining health promotion amongst various universities in Uganda, East Africa. It discusses six complexities to communicating health in these

universities, which include the influence of the biomedical and behavioural paradigms; competing communication contexts; diverse health and epidemiological issues; lack of clarity of vision for health; inadequate funding and misinformation and fake health news. In **Chapter Six** Konosoang Sobane proposes multivocality and multilingualism as tools for effective teenage pregnancy campaigns, by reflecting on the characteristics that define these programmes. It specifically assesses how the lenses of inclusivity, multivocality and co-creation can be harnessed to enhance the reach and impact of messaging in these strategies, drawing examples from COVID-19 communication experiences in Lesotho and South Africa. Using examples from two indigenous practices, the chapter highlights the need to draw from indigenous and cultural practices in conceptualising teenage pregnancy interventions. Mmakwena Molala acknowledges the importance of language as a medium of health communication, specifically in a multilingual and multicultural context of South Africa in **Chapter Seven**, by exploring how indigenous languages were used to disseminate knowledge during the COVID-19 pandemic, and if knowledge dissemination in various languages was adequate. Employing the diffusion theory as its theoretical base, and a document analysis method, the chapter concludes that language plays an important role in terms of knowledge dissemination and the understanding of the knowledge disseminated. The implementation of language policy, specifically the indigenous language to the level of English is still a work in progress.

### **The importance of tailored and targeted health interventions as well as communication systems**

The recipients of health communication interventions are important. In **Chapter Eight** Denish Otieno interrogates how communication on PrEP influenced action amongst young urban women from two East African cities; Kisumu, Kenya and Kampala, Uganda regarding HIV/AIDS prevention. The two-step flow theory was used to investigate how PrEP information infiltrates the complex interrelations, its gatekeepers and how messages influence various actions. Results show that communication on PrEP influence a positive action towards young urban women's'

acceptability of PrEP, while health facilities act as a key source of information on PrEP, with radio, television and newspapers as re-enforcers of PrEP information.

Meanwhile, the COVID-19 pandemic disinterred the importance of having an efficient health communication system as Rethabile Khantse Malibo critically analyses the health communication system in Lesotho in **Chapter Nine**. The chapter seeks to address critical questions regarding the significance of an efficient health communication system during crises. Multiple deficiencies and obstacles in the health communication system were identified, and the chapter illustrates that building an effective communication system encompasses more than just the tenets of communication as factors such as political will and commitment, public trust, managing public emotions, building competent media systems and stakeholder engagement, must be taken into consideration.

Finally, research about health communication is subservient as it serves to bridge the gap between scientists and practitioners as well as informing health promotion, prognosticate behavioural and other outcomes. The final chapter of this book by Ijeoma Dorathy Ajaero is a scopus of health communication research published in two health communication journals and two public health journals from major reputable international publishing outfits, over a period of five years (2018 to 2022), to identify health communication research conducted in sub-Saharan Africa; the nature of collaboration between scholars, theories and method(s) prevalent in the study area. The chapter attempts to critique research in sub-Saharan Africa with a special focus on the West African context.

In sum, from a sub-Saharan African point of view, multilingualism, indigenous platforms and decoloniality contribute to effective health communication in these particular contexts as applied and discussed in the book. The scholarship of health communication covers communicators who may be individuals or organisations that communicate messages that nurture the advancement of well-being and health amongst individuals, group, community or societal target audiences.

Disseminated health messages and channels of communication amongst various audiences are core to communication through the use of a variety of indigenous, interpersonal, mass, social and digital media platforms, and that research is crucial to understanding audiences' receipt of health messages and responses to them as well as predicting behaviour.

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# Chapter 1

## The changing practice of health communication through digitalisation across sub-Saharan Africa

Karabo Sitto-Kaunda 

### Abstract

Access to the Internet has significantly altered the practice of healthcare communication. Through the Internet-enabled Fourth Industrial Revolution (4IR) digital technologies have seen the growth of media convergence for disseminating and accessing health communication. Digital communication technologies have also enabled the building of support communities online intending to destigmatise previously taboo health issues, and quick responses during pandemics such as the Coronavirus disease 2019 (COVID-19) pandemic. There has been a convergence of online communication of various health practices, from Western and traditional to alternative medicines. While the digitalisation of healthcare and health communication has increased access for ordinary, mostly young citizens, sub-Saharan Africa (SSA)'s Internet penetration rate is lower than the global average, with those most desperately in need of healthcare often excluded as a consequence of the digital divide (GSMA, 2023). This chapter highlights the many opportunities for digital health and communication. It uses a case study to demonstrate such opportunities and discusses the digital health and communication risks that arise from misinformation and infodemics.

**Keywords:** digital communication technologies; digital health; e-health; media convergence; Fourth Industrial Revolution (4IR)

## Introduction

The Fourth Industrial Revolution (4IR) has given rise to a significant growth in digital communication technologies. These technologies have disrupted the communicative practices of many segments, including health communication, both at the interpersonal and mass levels of communication, and have given rise to digital health, also referred to as eHealth (Mawere & van Stam, 2020). Digital health, or eHealth, is defined as the interconnectedness of health systems and digital technologies, including information communication technologies and media, to aid in health management, communication, and promotion (Adeola & Evans, 2018; Fayoyin, 2016). Digital health has shifted the communicative balance of power from healthcare professionals, policymakers, and institutions as experts that could not be questioned by healthcare-seekers and the public to a more dialogic relationship. The health burden in Africa remains persistently high and needs innovative communication approaches to be applied to advance the continent's public health agenda (Fayoyin, 2016).

The use of digital technologies has brought positive physiological and psychological benefits to health communication practice. Social media communities' online interpersonal interactions can become an extension of offline personal networks (Soriano & Gutiérrez, 2015) and may also be easier to enter than in-person communities because they are more open (Matusitz, 2014). Digital health has also allowed for easier access to communication in more languages, although *linguae francae* are still primarily used (the challenges of this will be discussed). Engaging in online social media network communities can increase an individual's social capital and improve their psychological well-being (Malinen, 2015).

This chapter begins by providing background on how digital communication technologies have facilitated changes in health communication. This is followed by an outline of the health practice context in sub-Saharan Africa, highlighting the parallel health systems practised on the continent. The discussion goes on to highlight the influence of digital communication

technologies on health practices, how these technologies have been used to democratise access to health information, as well as the key benefits of digital health communication. The benefits, however, are not without their challenges in the digital context. The challenges addressed in the chapter include online risks of misinformation, personal information access, and reputational risk. The digital divide is a key challenge in increasing access and reach to all stakeholders in Africa, often resulting in the exclusion of the most vulnerable and desperate groups. The chapter highlights the case of mental health accessibility as a key example of the benefits and drawbacks of digital health communication practices. The chapter ends with a discussion on the convergence of various health practices, communication channels, and messages for diverse audiences across the African continent, and the critical role of health communication experts.

## **Literature review**

### **Health information digitalisation**

Knowledge asymmetry in health communication is becoming a matter of the past as information is democratised through digital communication technologies. The increased access is driven by the growth of Internet access globally, although in Africa low Internet penetration rates continue to persist when compared to the global averages (GSMA, 2023). The Internet penetration rate of 39.3% in Africa lags the global average by 24% (Statista, 2024). This persists despite the United Nations in 2011 declaring Internet access “a catalyst for the enjoyment of human rights” (Psaila, 2011). Multiple technological innovations, channels, and platforms have enabled health communication to grow in reach beyond immediate contexts, especially for healthcare practitioners. Digital communication technologies have been recognised as beneficial and are increasingly used in health communication by healthcare practitioners (Western and traditional) and public organisations alike.

The mobile phone’s ubiquity has been critical to driving Internet access on the African continent, particularly for a

continental population that has a reported median age of 19.7 years old (Worldometers, 2022) – the youngest average age globally (Lubinga & Sitto, 2021). However, according to GSMA reports, mobile penetration disparity – that is, population access, use, and network availability – in rural Africa is stark (Mawere & van Stam, 2020). One of the other challenges concerning digital communication and health involves literacy and technological skills for the African continent.

The opportunities for health communication practice have increased exponentially through the growth of digital communication technologies, from static websites to more engaging channels including social media, mobile applications, forums, instant messaging, and telehealth (Mbunge et al., 2022). Online communities and interpersonal communication technologies have enabled healthcare practitioners to become closer to their stakeholders, and for the stakeholders to be closer to one another. The traditional definition of a stakeholder, originally defined by Freeman (1984), as one that can affect an organisation's objectives has evolved to recognise the critical need for stakeholders as vital to the success and sustainability of an entity (Freeman et al., 2004). In a digital environment, stakeholders have become co-creators in the development of communication messages and content, including in health communication.

### **Health practice context in Africa**

The practice of healthcare has multiple levels and layers, primarily driven by interpersonal interactions between healthcare-seekers and healthcare practitioners, as well as within the healthcare sector itself. The African continent has performed poorly in healthcare, with continental health indicators much lower in Africa than in other regions around the world (Adeola & Evans, 2018). The layered landscape of healthcare as well as the life and death implications of it make health communication a critical strategic area of practice, particularly in the digital age on a continent with the youngest average population. Technological advances in digital communication media and technology hold good promise in driving communication, which is central to

the successful delivery of public health on the African continent (Fayoyin, 2016). There is a positively correlated relationship between digital health communication technologies and health outcomes (Adeola & Evans, 2018). Healthcare, particularly on the African continent, is broadly divided into public and private healthcare, organised along the lines of economic affordability. Socio-economic inequalities influence the quality of healthcare that individual citizens receive as well as the health information that they can access. Digital technologies have reportedly been used successfully in numerous countries in southern and eastern Africa to improve disease surveillance in public health (Adeola & Evans, 2018).

Health communication can be broadly categorised into several contexts, including interpersonal and institutional communication, amongst others. At an interpersonal level, the communication is between healthcare-seekers and healthcare professionals in a personalised consultative setting. During these engagements, healthcare professionals often communicate the matter that healthcare-seekers are consulting about, and potentially use medical jargon to explain. There is often knowledge and information asymmetry in these interactions and a reliance on expertise during such communication. At an institutional level, governments and other health institutions, including non-governmental organisations, communicate issues of health at a societal level, primarily addressing public health communication. These include communication about diseases, epidemics, and policies in response to health matters. Institutional health communication takes place at a mass level, with limited opportunity for engagement with intended audiences.

Within health communication, consideration needs to be given to the diversity of health practices in Africa. The continent has multiple, parallel systems – Western, traditional, and alternative medical practice. The communication of these differs in the underlying assumptions, beliefs, and practices of each. Some of the most dominant health communication is Western-centred, and it vilifies traditional and alternative medicine at times.

### **Influence of digital communication technologies in SSA health communication**

The growth of digital technologies for communication has altered health communication practices, and this trend will continue. Healthcare practitioners and institutions have traditionally controlled the communication about matters of health, including the messaging as well as channels of communication. However, 4IR communication technologies have fundamentally altered how communication takes place, particularly with the growth of computer-mediated communication and the exponential growth of social media. Digital health has multiple uses, including communication, awareness creation, screening, surveillance, monitoring, and compliance (Mbunge et al., 2022). The growth of the Internet has facilitated the explosive growth of digital technologies, enabling communication and interactions that are not time or geographically bound. Digital innovations such as “Kena Health”, a South African healthcare mobile app, allows healthcare-seekers to consult with a healthcare professional via text, voice, or video to seek medical interventions from anywhere in the country (Kena Health, 2022). Such phenomena have democratised knowledge and information, bringing about significant opportunities to reach previously unreachable individuals through various channels and platforms. The use of communications networks has however been slowing down in developing countries, coupled with stalling Internet rollout (Mawere & van Stam, 2020), thus limiting access to digital communication technologies on the African continent.

Communication technologies have become richer over time, reducing concerns about digital communication social cues. Hyperpersonal communication is a response to digital online communication, helping to develop online community engagement norms using a variety of tools to extend digital communication social cues (Sitto, 2019). Technologies such as video calls have become cheaper and more accessible, making it possible for healthcare professionals to consult remotely, participate in life-altering surgeries, and engage directly with healthcare-seekers without geographic boundaries being a concern. The benefits of digital health include improved

healthcare service access, especially for people living in hard-to-reach areas (Olu et al., 2019). Hyperpersonal computer-mediated communication technologies enable interpersonal online engagement and relationships that go beyond the closeness that is experienced in similar offline interactions (Walther, 2011). Digital communication technologies may be used as a more efficient and cost-effective means of providing healthcare by practitioners, remotely managing patients in the place of transporting healthcare specialists to rural and hard-to-reach areas (Adeola & Evans, 2018). Digital communication technologies have made communication and access to leading global health experts much easier, including the ability to observe and give social cues. Health communication has been enriched by digitalisation, especially where health communication experts have designed and produced quality health promotion messages accepted by digitally connected, informed, and mobilised communities (Olu et al., 2019).

Digital communication technologies include both online and offline contexts. The online technologies are powered by the Internet, which has become increasingly accessible. Through media convergence, digital online communication channels combine mass and interpersonal communication, disseminating messages to broad audiences, while also engaging users in interpersonal interactions (Kreps, 2017). The Internet penetration rates on the African continent, however, remain pervasively lower than global averages, mostly due to limited investment in the infrastructure required. Adeola and Evans (2018) found that in selected African countries such as Algeria, Morocco and Tunisia, there was a positive correlation between life expectancy, Internet usage, and mobile penetration – that is, higher Internet use in selected African countries. The mobile phone's ubiquity in Africa (labelled Africa's laptop), has been instrumental in increasing Internet access on the continent. While the mobile phone and Internet penetration in Africa is enough for scaling digital health and communication, it remains lower than the global average (Olu et al., 2019). In Africa's history, mobile phones have become the most common technological device over a short period, and continue growing in usage (Adeola & Evans, 2018). A good

example of the power of mobile health communication is the use of mobile phones, amongst other digital and traditional channels, through credible voices of community leaders and traditional healers in combatting the spread of Ebola in 2014 across West Africa (Lubinga & Sitto, 2021). Mobile phone access, however, remains skewed to younger, urban citizens, leaving out elderly and rural-based citizens, who make up the largest populations on the African continent. Mbunge et al. (2022) recommend the growing of rural area community networks to bridge the digital divide in developing countries. The digital divide refers to the gap between those people who have access to modern information and communication technologies, and those who do not have access or have restricted access (Van Dijk, 2017).

Internet access is organised along the socio-economic lines of affordability, considering that access is generally expensive. The constraints of mobile phone usage include prohibitive costs, limited access to handsets, restriction of content, unreliable network service, and limited tailored health information (Fayoyin, 2016), thus limiting the exclusive use of digital health communication practices. The price of connectivity plays a crucial role in the enablement of digital health communication and access on the African continent. As of 2012, the cost for one gigabyte (GB) of mobile data in Africa varies significantly across the continent, from as low as \$0.27 in Sudan up to \$50 in Equatorial Guinea (Statista, 2021). These mobile data costs are prohibitive when put in context: according to Andres Castaneda Aguilar et al. (2019), on average, approximately 85% of sub-Saharan Africans survive on \$5.50 per day.

Critical health messages using online digital technologies often fail to reach citizens who are not online, so word of mouth and re-sharing of critical health communication messages become crucial. This practice of passing down information means that critical health communication information may be lost, or distorted, adding to delays in individuals taking appropriate action. While Internet-driven technological developments and mobile infrastructure expansion have increased the deployment of social media devices for health communication and education across the globe, reach and media access asymmetry exist

societally in Africa (Fayoyin, 2016). In rural areas, mass media such as television, radio and newspaper remain the largest and most reliable sources of information, because of their exclusion online. Developing economies continue to struggle with increasing online digital access to citizens, especially because of the challenges experienced with delivering basic services that include communication about healthcare.

The digital divide on the continent perpetuates the public / private healthcare and access divide, with the more affluent being able to access online healthcare messages and communication more easily. Those excluded from online and digital health communication are often those in the most desperate need of the information, especially because of socio-economic challenges of affordability. The digital divide may thus be undermining health communication efforts aimed at informing, educating, and influencing behaviour amongst citizens.

The language used in health communication is another matter of strategic consideration, as the use of health jargon can result in misunderstanding and confusion with audiences. Health communication language continues to become more accessible, particularly through the growth of online communities for support and engagement to interpret the jargon. However, the linguistic challenge persists in Africa, where most digital and online channels cater mainly to *linguae francae*, excluding large segments of rural individuals who speak regional and local languages / dialects.

## **Digital health practices**

### **Use of digital health communication for the democratisation of information**

Health communication has historically been highly regulated, with global health issues shared through the World Health Organization (WHO) and respective member governments, who disseminated information to localised healthcare professional bodies. These bodies were the mediators of health messages and sanctioned all forms of communication about health matters

to the public and healthcare-seekers. Information was used primarily as a tool to control access to information. Digital and online communication technologies have permanently changed how and where communication takes place, even for health communication. Disintermediation has removed barriers between message originators and recipients, thereby democratising access to the means of communication, information, and knowledge. Health communication has also undergone significant changes through digitalisation, where healthcare professionals and healthcare-seekers are more directly engaged. Patients now interact with their doctors through instant messaging services, building a far more personalised relationship. Citizens can directly message or tag national health ministers, health institutions, and leaders concerning health communication and response to messages issued to them.

The COVID-19 pandemic context forced healthcare practitioners and institutions to rely more on digital technologies for the dissemination of critical health information and engagement. In South Africa, for example, the government and the healthcare system adopted multiple digital technologies as part of the strategic communication response and to provide services to healthcare-seekers during the COVID-19 pandemic (Mbunge et al., 2022). The technologies included mobile, telehealth, instant messaging through WhatsApp, chatbots, and robotics (Mbunge et al., 2022; Sitto et al., 2022). During the health crisis, governments increased their use of digital media to share information with citizens, although the challenge was the effectiveness of using these technologies (Sitto et al., 2022). According to Kreps (2017), digital and online health communication systems need to be easy to access and suitable to the users of those communication systems, which was not always the case for Africa's public health response to COVID-19. Disintermediation takes the power of control of information out of the hands of the limited few, namely healthcare professionals, organisations, and institutions, making it available to many ordinary individuals. Thus, health communication has become a contested sphere, especially in the digital space, where there are diverse beliefs, practices, and levels of access to healthcare services.

However, digital communication technologies such as social media have enabled individuals to develop and create communities of support for health-related matters, including chronic illnesses such as HIV/AIDS (human immunodeficiency virus / acquired immunodeficiency syndrome), diabetes, malaria, and others. Social media has been proven to have psychological benefits, particularly for those feeling isolated, for example through disease. Healthcare practitioners participate online and are part of online communities, lending expert voices to online conversations and guiding them. Traditional and alternative healthcare practitioners have also increased online participation. Previously, these health practices were shrouded in mystery; however, through digitalisation, they have become more accessible to individuals, who can access more information about them. Traditional and alternative healthcare practitioners have allowed for online consultations on matters previously available only during in-person consultations. Digital communication about traditional and alternative healthcare practices has grown and become normalised in online communication, helping healthcare practitioners to overcome stigma, reduce fear and demystify their practices.

Digital health communication is holistic in nature and includes physical, emotional, psychological, and spiritual health. Health communication has thus extended beyond the physiological elements to focus on an individual's overall state of wellness. The online convergence of Western, traditional, and alternative health has moved digital conversations to dialogues on the intersections between the practices and the sharing of information.

### **Digital health communication benefits**

The interpersonal and public contexts of health communication are converging, with the rise of computer-mediated communication, digital technologies, and increased power being in the hands of individuals. The digital landscape builds Mecosystems that centre on the individual's health communication wants and requirements (Verwey & Muir, 2018). The individual in a digital and online communication context is

at the centre of all information and technologies, designed and tailored to individual tastes and preferences.

Social media has provided online spaces for individuals to build and participate in support communities for various health matters. These health issues may include communication of previously taboo issues such as HIV/AIDS through support groups. The power of social media is the ability for individuals to participate anonymously, yet reap the benefits of being part of an online community. Through these digital health social media communities, individuals can engage in self-disclosure, communicating their thoughts and emotions (Jiang & Hancock, 2013:557), all of which help to build online intimacy between health communication participants. This includes self-disclosure facilitated by access to leading healthcare experts on matters of personal and public health – for example, the COVID-19 pandemic, spiritual traditional health consultations, chronic illness matters, and health lifestyle metrics from wearable health devices.

Mobile phone applications for tracking health measures are useful applications for digital health communication. Increasingly, more healthcare professionals and seekers use digital communication channels to communicate critical health issues and gather relevant health data (Kreps, 2017). The use of advanced digital technologies for reaching remote areas with pharmaceutical interventions such as drone distribution of medication used in Rwanda (Shepherd, 2022) are some of the benefits of digital health on the continent where communities are remote from urban centres. For Africa to reap the benefits of digital health, approaches need to be coordinated and synchronised to ensure a quick, wide-scale rollout of the required technologies through establishing strong governance, regulatory mechanisms, policies, and strategic tools (Olu et al., 2019). One of the most critical benefits of digital health communication is the holistic approach to health that is Western, traditional, and alternative, all available to healthcare-seekers. It has helped demystify some practices, lowered the potential barriers to information access and potentially driven more disclosure of the engagement in parallel healthcare practices by healthcare-seekers.

## **Digital and online health communication practice risks**

Along with the numerous benefits of digital health and communication there are some serious challenges, especially misinformation and personal security. The successful implementation of online and blended systems in the 4IR requires the appropriate skills to be able to work with the technology (Kayembe & Nel, 2019). Digital literacy is a challenge for digital health (Mawere & van Stam, 2020), especially in ensuring the comprehension and efficacy of health communication messages distributed through digital communication technologies. The reality is that the mobile phone may have grown, yet the majority are not smartphones, which allow for the development and use of mobile applications. Poor Internet and network connectivity can also cause delays in time-sensitive health communication (Mbunge et al., 2022).

Digital communication technologies have democratised the distribution and sharing of information. The Internet is widely used to seek health information; however, online health information sources are also considered sites of mass misinformation (Fayoyin, 2016). Misinformation is harmful, as it may involve the deliberate spreading of fake news and lead to infodemics (Tropina, 2023). According to de Rosa et al. (2021), an infodemic occurs when there is an information epidemic that mixes facts, rumours, as well as fake news in all communication domains. A large challenge concerning misinformation has involved the reputations of healthcare practitioners (e.g. Dr Wouter Basson also known as Dr Death), government officials, and institutions (Netcare hospital group and DR Basson), as took place in South Africa (Marbot, 2021), as well as discrediting official critical public healthcare information.

Misinformation about health communication and messaging can be harmful for recipients of digital health communication. The harmful practices include the promotion of fake healthcare practitioners (Pensulo, 2024), human trafficking recruitment for organ harvesting, as well as the distribution of incorrect or life-threatening medical advice. Young people, who make up a large majority of those connected online and through

social networks, are particularly vulnerable online. Digital online platforms such as social media can lure young people into consuming inappropriate content about health (Fayoyin, 2016; Busby, 2024).

Health information and communication are sensitive, requiring consideration, particularly of the protection of personal information, given the vulnerability of sensitive personal information online. One of the most critical hurdles to the successful implementation of digital health is that African governments lack the adequate legal framework and capacity required to address ethical issues of digital health data ownership and consent of use, as well as online security (Olu et al., 2019). Security and privacy issues are critical issues in digital health communication that can impede growth in the adoption and use of digital health tools and communication channels, fuelling a lack of trust in healthcare professionals and seekers in digital healthcare systems to keep data and personal information secure (Mbunge et al., 2022).

The evolution of digital health communication practices may perpetuate the exclusion of the most vulnerable in society due to the digital divide, thus influencing social behaviours and health outcomes due to information asymmetries. The African continent is made up of demographically diverse individuals who all have different levels of competence in their usage of the Internet. Rossouw et al. (2018) call this the technological generational divide. The digital health communication engagement of healthcare-seekers and professionals online is also prone to personal attacks and acts such as cyberbullying (online bullying), which can have damaging psychological consequences (Yosep, Hikmat & Mardhiyah, 2023).

Digital health initiatives and communication practices need to be context-specific and be results-driven (Olu et al., 2019). Communication technologies can increase the physical and psychological distance between communicators and audiences because of a lack of hard-to-detect non-verbal cues that may lead to stereotyping (Matusitz, 2014; McQuillen, 2003) and ultimately ineffective health messages. If digital health communication

practices fall short of benefiting the intended recipients, they potentially waste valuable yet scarce health communication resources in countries across the African continent.

### **Healthcare accessibility through digital communication media: The case of Mental health**

Mental health attracts both public- and self-stigma, according to McLean Hospital (2024). The area of mental health and communication about it is largely taboo and hegemonic across Africa, at times referred to as a silent epidemic (Africa CDC, 2023; Amuyunzu-Nyamongo, 2013). There is little focus on mental health and even less on communication about mental health. A large proportion of African countries do not have dedicated mental health policies, as evidenced by the Africa CDC (Centres for Disease Control and Prevention) (2023) encouraging member states to invest in prioritising mental health. Mental health issues in Africa are often considered Western-induced. The traditional African medical approach to mental health is more holistic in treating the afflictions of an individual (Amuyunzu-Nyamongo, 2013). In traditional African settings, a single individual's mental challenges are attributable to the whole family, which may be considered cursed (Kpanake, 2018). Increasing health communication campaigns focused on the importance of mental health have raised awareness in African communities of such afflictions as medical issues (Africa CDC, 2023). For Africans living in a modern context with mental healthcare specialists, there is a range of available therapies that are becoming more mainstream and more easily accessible.

The approach to healthcare consultations, including mental health, remains focused on providing privacy and confidentiality for the patient, irrespective of whether the context is Western or traditional. The growth of digital communication technologies has further aided confidentiality because people do not have to consult in person; this also makes it more affordable, especially for rural-based individuals (Mindu et al., 2023). Hyperreal (also hyperpersonal) communication has become more desirable in some contexts than contact interpersonal interactions. In the last decade, remote mental healthcare consultations have become

more prevalent globally, with reliance on digital technologies for consultation that include video conferencing, telephone, and voice notes. Mental healthcare practitioners, particularly in a difficult African context where their patients do not always enjoy support for accessing such services, have been able to provide more privacy through computer-mediated consultations (Tshephe, 2023). One such service has been the growth of crisis hotlines in some countries such as Burundi (e.g., open counselling) and South Africa (SADAG, Childline, Akeso, Department of Social Development's substance abuse 24-hour helpline, etc.), which citizens may call anonymously to discuss their mental health challenges while enjoying privacy.

Hyperpersonal communication through various tools gets around the limited social cues available online to ensure better interpersonal communication. Such interactions are convenient as they allow individuals to access mental healthcare services and seek information without the prying eyes of their community or the possibility of facing stigmatisation for such consultations. Virtual communities have also come into existence to provide support for individuals seeking mental health information and interventions while avoiding being stigmatised in their communities. COVID-19 further perpetuated the stigma around mental health (Williams, 2020). The blended approach to mental health consultations had become normalised, especially in urban settings, even before the COVID-19 pandemic. With physical distancing an imperative at the height of the COVID-19 pandemic, and several African states having implemented lockdown strategies for their citizens, the limited access to mental healthcare was placed at even greater risk. The restricted movement forced healthcare practitioners, including those focused on mental health services, to pivot their methods of practice towards digitally supported methods to ensure that their patients were not left uncared for or vulnerable (Békés et al., 2021).

While digital technologies have improved access to mental health information and care, the African context remains one of unequal access not only to digital technologies but to limited resources. The digital divide, particularly in Africa, is perpetuated

by poverty and an inability to gain access owing to affordability, as well as a lack of digital technology skills to use communication technologies effectively. In the context of mental health, the largest barrier to health communication remains stigmatisation, followed closely by competition for limited healthcare resources due to the high prevalence of disease amongst populations. The competition for health resources results in a disproportionately low investment in mental healthcare and communication across the SSA region (Africa CDC, 2023). The case of mental health access, however, provides a good case for the use of digital technologies that can balance healthcare needs with maintaining societal positions outwardly. The focus thus needs to widen towards more vulnerable and disadvantaged communities, taking the lessons from existing digital solutions to mental healthcare access to develop converged communication strategies.

## Discussion

### **The power of media convergence for digital health communication**

The development of converged health communication strategies in Africa recognises and includes powerful mass media to develop successful and effective health communication practices within communities. Digital and social media technologies may be recognised for their vast potential benefits in health communication efforts; however, they should not be treated as a panacea for health communication practice (Fayoyin, 2016). Media convergence is the process where the same information becomes accessible through a variety of media types, content, and devices – e.g., radio, social media, newspapers, etc. Kreps (2017) argues that media convergence can improve health education, promotion, as well as behaviour change.

Harnessing the power of digital communication media and technologies to build collaborative and co-created health communication strategies will build relevance and drive message effectiveness across the continent. Digital communication technologies can assist health communication experts in

developing feedback loops through digital engagement that are almost immediate in response to health messages published and distributed to inform health communication practices. The reality, however, is that the majority of the African population resides in rural areas and thus only localisation aligned to rural realities (affordability, language, Internet access, traditional media access, etc.) can result in meaningful health communication interventions for sub-Saharan Africa (Mawere & van Stam, 2020). The digital communication levels of access and skills of diverse African audiences cannot be ignored, as they inform what digital health communication approaches are possible to undertake.

Digital health communication still requires the skills of health communication experts to understand the digital communication landscape, messaging requirements, intended audiences as well as their levels of media access to design successful communication. Digital communication media have enabled stakeholders to become co-creators and collaborators of online content (Sitto & Lubinga, 2021) and thus empowered, even in health communication messaging to initiate, engage, and curate such content. The convergence of information, technology, and connectivity to improve healthcare and health outcomes in countries with lower access levels can be tested through small pilot projects (Adeola & Evans, 2018). The value of co-creation and collaboration for effective converged health communication in the digital age should thus not be overlooked.

### **Conclusion**

Digital communication technologies have disrupted health communication practices, as technologies have brought information closer to ordinary individuals. The parallel healthcare systems existent in SSA complicate the health communication landscape further, with the advent of digital health communication. Socio-economic inequalities continue to influence not only access to healthcare but also access to health communication interventions, especially on digital channels, widening the digital divide further, particularly for rural citizens. There have been numerous benefits gained through digital health communication, including increasing access, enabling

the development of online health support communities, and bridging the knowledge gap for rural communities. However, the risks of democratised digital health communication cannot be ignored as they have life-threatening consequences, including misinformation, distortion of health messages, and the promotion of fake healthcare practitioners, raising questions of digital safety, health data ownership, and digital health content trustworthiness. Numerous other risks beyond digital exclusion plague digital health communication, including affordability, language barriers, limited digital access, and potential access to sensitive personal health information. The benefits of digital health communication enable individuals to access sensitive information, such as in the case of mental health in SSA and demonstrate the importance of digital health integration for meaningful stakeholder engagement. Media convergence in health communication is imperative to ensure that information is disseminated in a manner that is contextually relevant, inclusive, and accessible for digital health communication to be effective. While digital health communication grows and technologies are increasingly integrated into health communication strategies, practitioners cannot rely exclusively on them to ensure message effectiveness to reach diverse audiences with key health information.

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## Chapter 2

# A Whole-of-Society (WoS) Approach to Health Crisis Communication in Ethiopia Intersecting Indigenous, Traditional, Social and Interpersonal Media

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### Abstract

Health communication is crucial to raising public consciousness about general and specific health problems and to making members of the public responsible for their own health and safety. Preventing health problems is an easy and effective way to keep the public healthy, and in this regard designing context-specific health communication strategies is vital. The disruption caused by the Coronavirus disease 2019 (COVID-19) outbreak demanded pertinent health communication to prevent the spread of COVID-19. This disrupted situation suits the Diffusion of Innovations Theory. Data collected using in-depth interview and qualitative content analysis for this study reveals that Ethiopia uses a "whole-of-society" (WoS) approach in health communication, which incorporates multiple and integrated communication channels, opinion leaders and change agents. Both general and specific health crises, for example the outbreak of COVID-19, make it imperative to provide the public with the necessary health information to change their behaviour, which is not easy. Logistical problems and the paucity of communication materials as well as lack of expertise and negligence are challenges

for health communication. Generally, health communication has been effective in raising the public's consciousness about health issues and has contributed significantly to universal health coverage. However, COVID-19 forced health communication to extend beyond awareness-raising and persuasion of people to changing their behaviour in Ethiopia.

## **Introduction**

Health communication is crucial and effective to raising awareness, increasing knowledge, shaping attitudes and changing the behaviour of the public. It is indispensable to keeping the public healthy, especially in a country such as Ethiopia that cannot afford curative health services. Hence, health communication that is accurate, accessible and understandable is necessary in general and particularly essential at the time of a pandemic, as in the COVID-19 outbreak.

Health communication empowers the public to be responsible in healthcare activities, which in turn, improves the success and effectiveness of healthcare delivery. The outbreak of COVID in 2019 demanded resilient health communication to keep the global society safe. The World Health Organization (WHO), the main source of health information, provides reliable general health information and specific recommendations for pandemics such as COVID-19. As per WHO recommendations, the Ministry of Health and the Public Health Institutes in Ethiopia designed general and specific health communication guidelines to develop the public's awareness and keep it safe. Available communication and media technologies during health crises make the dissemination of timely, reliable and accurate health information possible. However, there is the danger of information overload, which can cause the spread of disinformation, which in turn creates panic amongst the public, especially in the case of COVID-19. Therefore, health crisis situations demand health communication that is timely, accurate, and credible to increase public awareness, influence perception, and reinforce behaviour change. This chapter showcases how Ethiopia used a "whole-of-society" (WOS) approach to health that amalgamated several media during the COVID-19 pandemic. The

Diffusion of Innovations Theory fits the WOS approach to health communication that was followed by Ethiopia.

## Literature Review

### **The Essence of Communication and Health Communication**

Communication is a process of transmitting and sharing information to create a mutual understanding for desired action between communicators (Van Ruler, 2018). Mutual understanding between communicators is crucial and determines the success of communication. Communication takes place in particular social contexts. Due to contextual influences, discrepancies between the messages sent and received are anticipated and may occur in the process of communication. What is more, communication is a dynamic process in which sources and receivers of information continuously interchange roles (Rimal & Lapinski, 2009). Hence, it is necessary to take the facts described into consideration in designing communication strategies.

A health policy that recognises health as a prerequisite for development is crucial, because a healthy society is essential for the holistic development of a state. To achieve its health policy goals, Ethiopia has followed a national health strategic plan organised into five-year periods since the 1990s. Subsequently, the Ministry of Health (MoH) developed the Health Sector Transformation Plan (HSTP) in two phases to address societal health demands. HSTP-I, implemented from 2011/12 to 2015/16, focused on transformative health system changes. HSTP-II, running from 2020/21 to 2024/25, aims to improve the population's health through four main objectives: accelerating progress towards universal health coverage, protecting against health emergencies, achieving woreda transformation, and enhancing health system responsiveness (MoH, 2023).

Thus, health policy requires effective health communication to raise public awareness about health problems. This not only raises the consciousness of members of society but also makes them responsible for their own health. Therefore, the health policy of Ethiopia has boldly recognised the importance and

necessity of health communication and health education to keep the workforce productive as well as the society healthy (Yetena Weg, 2021).

Health communication is defined by certain key phrases: “sharing meanings or information,” “influencing individuals or communities,” “informing,” “motivating target audiences,” “exchanging information,” and “changing behaviours”. These describe the role of health communication (Oxman et al., 2022; Schiavo, 2013). Health communication is the study and application of a strategy for the generation, creation, and dissemination of health-related information, health-related interactions amongst individuals, social actors and institutions, and their effects on different members of the public, including individuals, community groups, and institutions, which ultimately facilitates the prevention and treatment of diseases (Glanz et al., 2008). What is more, effective public health initiatives require informed, strategic, and culturally sensitive communication. A multifaceted and multidisciplinary approach to health communication is essential for societal development. Utilising various mediums – such as mass media, interpersonal communication, digital platforms, and community engagement – greatly enhances the dissemination of health information and the promotion of positive health practices. Community involvement is crucial, as it ensures that health messages are culturally relevant and empowers individuals to manage their own well-being. Clear and targeted messages, based on the latest research and tailored to diverse communities enable individuals to make informed health decisions, adopt healthier lifestyles, and engage in preventive measures (Uduak Udoudom et al., 2023).

Health communication is crucial to raising the consciousness of the public about general causes of health problems as well as specific and immediate health issues, like the COVID-19 pandemic, in a society. In handling the COVID-19 pandemic, effective risk communication can only happen with experts trained in communication, and there needs to be an emphasis on having communication experts involved (Faina Linkov et al., 2024). Crucially, it plays an essential role in developing the public’s awareness of health issues and

makes them responsible for their own health, which is very cost-effective.

## The Development of Health Communication in Ethiopia

Even though Ethiopia has a long history as a state, the modern health system, together with health communication, was introduced only recently. The attempt to design health communication dates back to the 1960s. Contextually, Ethiopia has a unique social, political and historical context. It is the largest and most populous country in East Africa with nearly 120 million people, who are diverse in ethnicity, religion and culture.



**Figure 1:** Regions of Ethiopia, Source: Wikimedia Commons (2023)

Since 1991, the political establishment has been based on ethnic federalism in order to address the political aspirations of the various ethnic, religious and cultural groups (Mehretu et al., 2024). It is also one of the fast-growing economies in the region (Asfaw et al., 2019). A growing economy and a diverse society demand a healthy and productive workforce. For this to happen,

a health policy that addresses the society's demand for universal health coverage is crucial.

Despite its long history as a state, Ethiopia did not have a well-defined health policy until the mid-20<sup>th</sup> century, when it formulated a comprehensive health policy document based on the WHO's recommendations to respond to health problems in the country (Wubshet & Engida, 2012). However, the outbreak of the Ethiopian Revolution in 1974 ended the first health policy before its implementation at full scale. Subsequently, in the 1970s, the military government designed a health policy that was aimed mainly at controlling and preventing diseases. The policy gave priority to the rural community's health situation, given that the majority of the productive population lived in the countryside. The policy stressed community engagement and participation as its main strategy to make society responsible for its own health. However, low economic development, the protracted civil war and low literacy rate hindered the effective implementation of the policy. The policy ended in 1991, when the EPRDF (Ethiopian People's Revolutionary Democratic Front) assumed power (Wubshet & Engida, 2012; Yetena Weg. 2021; FAO, 1993).

In 1993 the new government introduced a new health policy that aimed at decentralising health services in order to address the cultural, ethnic and socioeconomic differences of society as well as global dynamics (FAO, 1993; Yetena Weg. 2021). Since the policy aims at addressing the health issues of sectors of society that are highly diverse socio-economically, health communication and education has been considered a major tool to alleviate the health problems of society. Hence, due attention has been paid to health communication and education in the policy.

## **Contemporary Health Communication Practices in Ethiopia**

The 1993 health policy in Ethiopia duly stresses the importance of health communication and the use of multiple outlets to reinforce the messages to alert the public about the causes of health problems. In the health communication process, the participation of the public and the involvement of public opinion leaders

have been elicited in order to disseminate health information. Thus, the communication strategy employs different means to transmit health information for a psychosocially diverse society. The ultimate goal of health communication in Ethiopia as well as diverse societies, is to bring about positive behaviour change (MoH, 2017).

## **Designing Health Messages in Ethiopia**

In Ethiopia, the design and management of communication are decentralised. Hence, the communication strategies that attempt to raise the understanding of the public about general health problems and specific health problems like the COVID-19 pandemic have considered the different contexts amongst the 12 regions of the country. Health communication and education within the country, aim to raise public awareness about communicable and non-communicable diseases, emergencies, hygiene and sanitation, public toilets and waste management, food and nutrition etc. Moreover, health communication addresses health problems about how to prevent the transmission of HIV/AIDS from mother to child, syphilis and hepatitis. Furthermore, the Ethiopian Ministry of Health designed communication strategies to protect the public from the spread of COVID-19 at the time of the outbreak. The Ethiopian Ministry of Health works strenuously to educate members of the public about health problems in order to bring about behaviour changes and make them responsible for their own health (MoH, 2021; FMoH, 2020).

Ethiopia's Ministry of Health's 2016 National Health Promotion and Communication Strategy document (FMoH, 2016a), which aimed to guide grassroots health communication in order to bring about behaviour change, acknowledges the use of multiple communication platforms to diffuse health education easily and to reinforce health messages. The communication strategies also stress the importance of audience-centred messages that have sustainable coordination with health extension workers, the Women's Development Army, and community leaders to mobilise the public on health issues (FMoH, 2016b).

## **Strategies for Health Communication in Ethiopia**

Ethiopia practices a WoS approach to health, reinforced by practiced communication strategies. The WoS approach represents a very broad approach, that moves beyond public authorities through engaging multiple, relevant stakeholders, including individuals, families and communities, intergovernmental organisations, religious institutions, civil society, academia, the media, voluntary associations and the private sector and industry (Brinkerhoff et al., 2017). Various media are used for varying purposes to disseminate healthcare information such as interpersonal communication, health journalism, and TV and electronic communication. The use of multiple communication channels and choosing the right medium for the right audience is key to realising set health goals. A sound and effective health communication strategy should also have an overarching vision to address a particular health issue. Similarly, the mass media, traditional and indigenous media have been employed to disseminate health education to tackle various health problems in Ethiopia. Model families, and religious and traditional institution leaders (opinion leaders) are also part of the health communication process in Ethiopia (Kasaye, 2006; FMOH, 2016a).

The 2016 National Health Promotion and Communication Strategy focuses on:

- Inculcating the sense of responsibility for self-care and assurance of safe environment;
- Developing the public's consciousness to give due attention to promote a healthy lifestyle;
- Acquainting the public with communicable and non-communicable diseases and means of prevention;
- Encouraging the community to participate in health development;
- Identifying and discouraging harmful habits such as smoking and drinking alcohol; and
- Creating awareness about the use of drugs (FMOH, 2016a).

Communication strategies are a well-planned series of actions aimed at achieving certain objectives using communication

methods, techniques and approaches to solve health problems at grassroots level (Riera et al., 2023). Health communication strategies should have a long-term focus and respond to the need for individuals' behaviour change. They should also be integrated in order to maximise the potential impact on society at the broader level (O'Sullivan et al., 2003). In Ethiopia, health communication sets the goal of creating awareness about health problems, changing the public's behaviour and making members of the public responsible for their own health, which entails a healthy and sustainable lifestyle. Ethiopian health policy stresses the importance of health communication to keep the productive workforce healthy. Hence, the policy acknowledges active participation of public opinion leaders to diffuse health information and achieve the goals of health communication.

## **Theory**

### **Diffusion of Innovations Theory**

The Diffusion of Innovations Theory model was proposed by Rogers (1962) and explains how new ideas and concepts are spread in society to bring about social change. The model illustrates different steps to the diffusion of new ideas in society, and opinion leaders and change agents play a crucial role in this process. Rogers's theory suggests that in a community, adopters of innovations are labelled according to the speed with which they adopt a new idea. For instance, only 2.5% of innovators adopt the new idea immediately. These are often followed by approximately 13.5% of individuals who take some time to accept and use the new idea but take it up soon after the idea is introduced - these are called "early acceptors". The biggest group of the adopters, also labelled as "early and late majority" are 34% each respectively. The majority of adopters often fall under this category because humans avoid being the first or last in adopting a new idea. The late adopters, often addressed as "laggards", are approximately 16% and are those who do not acquire the idea immediately and when they do it is late. The Diffusion of Innovations Theory emphasises the participation of influential people as community change agents to diffuse new concepts amongst the public. Rogers

(2003) defines diffusion as the process by which an innovation (anything the adopters perceive as new) is communicated through certain channels over time amongst the members of the social system. The theory has multifaceted perspectives about social change in which people, innovations, media and environment affect how rapid change occurs.

The Diffusion of Innovations Theory model, which requires public opinion leaders' engagement, is the model employed to diffuse health information successfully amongst the Ethiopian public. The model stresses the significant role that innovators and early adopters play in the first phase of the diffusion process. Hence, prominent individuals and model families participate in spreading health information and bringing about behaviour change in society. In Ethiopia, specifically, the Women's Development Army, health extension workers and local leadership have numerous engagements to spread health messages and to influence the public's opinion towards the desired goals of health communication. In Ethiopia, the health office designates well-known and respected people in society, political authorities at various levels in the region, religious and social institution leaders in the community, and model families, in development activities in the local area as change agents and opinion leaders. These groups of people are expected to help spread the new practices, such as ways of greetings (from the common hand-shaking to bowing and using only expressions), frequent hand-washing, keeping physical distance and avoiding physical contact and social gatherings.

### **A Synthesis of Diffusion of Innovations**

Diffusion is the process by which an innovation is communicated through special types of communication in certain channels over time amongst the members of a social system. It is concerned with new ideas which are invented, diffused, adopted or rejected. The new ideas lead to certain consequences and social change.

The newness of the idea in the message content of communication gives diffusion a special character and causes some degree of uncertainty, which implies a lack

of predictability, of structure, and of information. In such circumstances, information is the main means to reduce uncertainty. Diffusion, which ultimately aims at *social change*, is defined as the process by which alteration occurs in the structure and function of a social system. In a society, social changes occur in various ways – for example, in the form of revolution or natural disasters.

Diffusion can be effected via both centralised and decentralised systems. In a centralised diffusion system, a small number of officials or technical experts who head up a change agency make decisions about when to begin diffusing an innovation, who should evaluate it, and through what channels it will be diffused. In a decentralised diffusion system, decisions are more widely shared by the clients and potential adopters. Here, horizontal networks amongst the clients are the main mechanism to spread innovations. These days, decentralised systems of diffusion have been found to be an effective alternative to centralised diffusion systems, which were assumed in the past to be effective.

## **Innovations, Information and Uncertainty**

Technological innovations can be deployed very effectively in the diffusion of information. The two components of technology, hardware and software, can be designed for instrumental action that reduces the uncertainty in the cause-effect relationships involved in achieving a desired outcome. Hardware consists of the tool that embodies the technology as material or physical objects, while software consists of the information base for the tool.

## **Characteristics and Decision Process of Innovations**

Innovations are characterised by four main issues: relative advantage, compatibility, trialability and observability. This characterisation helps to explain the different rates of adoption of innovations.

The *innovation-decision process* is the process through which an individual (or other decision-making unit) passes

from first knowledge of an innovation to forming an attitude, making a decision and either adopting or rejecting the new idea. These processes are conceptualised as consisting of five main steps: knowledge, persuasion, decision, implementation and confirmation.

## **Innovativeness, Adopter Categories and Rate of Adoption**

Innovativeness is the degree to which an individual or other unit of adoption is relatively earlier in adopting new ideas than the other members of a system. Accordingly, adopters are categorised into five groups: innovators, early adopters, early majority, late majority, and laggards.

*Rate of adoption* is the relative speed with which members of a social system adopt an innovation. When the number of individuals adopting a new idea is plotted on a cumulative frequency basis over time, the resulting distribution is an *s-shaped* curve. At first, only a few individuals adopt the innovation in each period; these are the innovators. Soon the diffusion curve begins to climb, as more and more individuals adopt. Then the trajectory of the rate of adoption begins to level off, as fewer and fewer individuals remain who have not yet adopted. Finally, the *s-shaped* curve reaches its asymptote, and the diffusion process is finished. The rate of adoption is usually measured by the length of time required for a certain percentage of the members of a system to adopt an innovation.

## **Elements in the Diffusion of Innovations**

The Diffusion of Innovations Theory model has four main elements: the innovation, communication channels, time, and the social system, which are identifiable in every diffusion programme.

- *The innovation*: the new idea, practice, or object to be diffused.
- *Communication channels*: the means to transmit the message and essential for the process.

- *Time*, an important element, involves the innovation decision process, in the innovativeness of an individual or other unit of adoption.
- *Social system*: the set of interrelated units that are engaged in joint problem-solving to accomplish a common goal.

## Opinion Leaders and Change Agents

Different individuals in a social system play roles in the process of diffusing innovation; they are called opinion leaders and change agents. Most innovative persons have been perceived as deviant in society and their acceptance and credibility is low. Therefore, their role in diffusing innovations is limited. On the other hand, there are members in society whose acceptance and credibility are high. They provide information and advice about innovations to many in the society and play the role of opinion leadership.

### Opinion Leaders

*Opinion leadership* is the degree to which an individual is able to influence other individuals' attitudes or overt behaviour informally in a desired way with relative frequency. It is a type of informal leadership, rather than a function of the individual's formal position or status in society and the system.

Opinion leadership is earned and maintained by the individual's technical competence, social accessibility, and conformity to the system's norms. Opinion leaders are quite innovative; but when the norms are opposed to change, the behaviour of the leaders also reflects this norm. By their close conformity to the system's norms, opinion leaders serve as an apt model for the innovation behaviour of their followers. Thus, opinion leaders exemplify and express the system's structure.

When opinion leaders are compared with their followers, they:

- are more exposed to all forms of external communication,
- are more cosmopolitan,
- have somewhat higher social status, and
- are more innovative.

One of the most striking characteristics of opinion leaders is their unique and influential position in their system's communication structure: they are at the centre of interpersonal communication networks.

### **Change agent**

A *change agent* is an individual who influences clients' innovation decisions in a direction deemed desirable by a change agency. They usually seek to obtain the adoption of new ideas but may also attempt to slow down diffusion and prevent the adoption of what they believe are undesirable innovations. Change agents use opinion leaders within a given social system as lieutenants in diffusion campaigns. Change agents are often professionals with university degrees in technical fields (Rogers, 1983).

### **Change Agents and Health Extension Workers in Health Communication in Ethiopia: A Crucial Interpersonal Link**

Health extension workers are strong partners and allies in the process of implementing the strategies of health communication. Health extension workers move from home to home to educate the community about the health issues in the area and follow up on behaviour change. In the process of moving from home to home, they disseminate basic health information. In this way, health extension workers significantly support the health communication activities as change agents.

The Ethiopian MoH has designed a health extension package to provide better health access and services to the public. The health extension programme aims to ultimately make health coverage optimal. The package mainly addresses the health needs of marginalised and economically needy groups of the society, i.e., pastoralists, agrarians, and poor urban dwellers (Giday et al., 2007; FMOH, 2020). The driving philosophy behind the health extension package is engaging the community and making them broadly responsible for their own health. To engage the community effectively, the Women's Development Army, various committee members, men, youth and religious leaders

are involved in disseminating health information and are capable of bringing about behaviour change (Nejmudin Kedir Bilal, 2011; Haymanot, 2013; Ramana, 2014; Abajobir, 2015; Asfaw et al., 2019; Yibeltal Assefa, 2019; MoH, 2020a; Swanson et al., 2021). Moreover, Admasu et al. (2016) explain that the health extension programme has succeeded in improving the health situation in Ethiopia.

Health extension workers actively engage in health communication and the education process to alert the public about the causes of general health problems and specific health problems in society (Feysia et al., 2012; Admasu et al., 2016; Demeke, 2016; Eregata et al., 2019; Asfaw et al., 2019). Health communication resonates to address the health problems in Ethiopia since many hindering factors such as poverty, low income of individuals and lack of trained professionals, scarcity of logistics, and low public health awareness, impede universal health coverage (Nejmudin K. Bilal, 2011; Eregata, 2019; USAID, 2024).

Health policy communication strategies in Ethiopia involve health extension workers, the use of multiple communication platforms and the participation of opinion leaders in the community to tackle various health issues, including harmful habits, hygiene, and family planning. Above all, health extension workers are credible messengers for health messaging, especially in rural Ethiopia. The outbreak of COVID-19 necessitated the design and implementation of appropriate health communication strategies and the participation of different stakeholders, including health extension workers.

## Discussion

### **Health Crisis Communication in Ethiopia during the COVID-19 pandemic: Lessons Learnt**

The outbreak of COVID-19 in Wuhan, China, caused serious problems for global health systems in multifaceted ways. Health workers struggled with the lack of effective drugs, insufficient

hospital services and medical supplies and logistics, amongst others (Zhu et al., 2020). Moreover, the pandemic severely disrupted economies and social cohesion within societies. The situation also persuaded governments to decide on unprecedented containment and lockdowns (De Blasio & Selva, 2020). Authorities urged the public to keep themselves safe from the risk of COVID-19 since medical infrastructure was not available. Above all, intense media reporting and an endless stream of information obsessed with absolute numbers increased the lack of trust in healthcare infrastructure and magnified the fear of the public about a collapsing health system (Caduff, 2020). In Ethiopia too, the proliferation of media messages about COVID-19 created confusion and panic in society because of the lack of clear and consistent health information. The situation forced the public to look for possible sources of health information from the various options. Health professionals, government authorities, and citizens were uncertain about the nature of the virus and the infection spreads and the serious impact on the daily life of the public. The uncertainty and rapid spread of COVID-19, above all, the drop in cases, hospitalisations, and deaths create panic in global society (Saroj Pachauri & Ash Pachaur, 2023) and in Ethiopia as well. In 2020, Ethiopia had the highest number of COVID-19-related searches relative to its population (Mumbere, 2020).

The challenge of providing accurate health information to the public was a global concern, not unique to Ethiopia. In the US, the CDC (Centers for Disease Control and Prevention) recognised the shortcomings of its communication policy during the pandemic. Government interventions often focused on information and risk perceptions rather than behaviour due to the prominence of the COVID-19 “infodemic” or the widespread interest in health (Dolores Albarracin et al., 2024).

To address a resultant health information need, the Ministry of Health of Ethiopia formulated a health communication guide, which emanated from the health policy that aimed at increasing health access for the whole population with primary, preventive, essential curative and rehabilitative health services, to deal with the spread of COVID-19 (MoH, 2020b).

However, communication needs to transcend merely producing and disseminating messages. The process requires an understanding of what moves the listener and must be able to do that. Moreover, communication embraces the listener's points of reference, culture, values, ways of relating to the world as well as interest and reason (Dutta, 2016; Parsons, 2013). The WHO also recommends taking the unique contexts of a state into consideration to develop communication strategies. In addition, the organisation suggests that communication should be accessible, actionable, credible and trusted, relevant, timely as well as understandable to achieve set goals (WHO, 2017).

Similarly, effective health communication strategies recommend contextualisation and the use of multiple media to bring about behaviour change as coherent, coordinated and integrated messages through multiple channels provide a trusted, recognisable, and credible platform to build interventions on communication (Kott, 2016). The Ethiopian Ministry of Health instructed its communication staff to design contextualised health messages, use multiple communication platforms and involve health extension workers in the process.

## **Health Communication to Prevent the Spread of COVID-19**

In May 2020, Ethiopia's Ministry of Health dispatched its COVID Communication Protocol to regional health offices and stakeholders to guide health communication about COVID-19. The document consisted of clear descriptions about how to develop, disseminate and monitor as well as control health messages. Moreover, the document elaborated about the languages and terminology to be used, and activities' evaluation procedures. The COVID-19 communication protocol ultimately aimed at empowering individuals, families, and communities to adopt preventive and health-seeking behaviour to keep themselves safe from COVID-19 (USAID, 2023).

Moreover, the National Communication Protocol for COVID-19, National COVID-19 Communication Response Strategy (NCCRS) (June 2020), National Public Health Emergency

Operating Center COVID-19 emergency preparedness and response minimum standards for quarantine, isolation and treatment centres in Ethiopia (March, 2020) and Arba Minch Town Administration Health Office Public Health Emergency Operation Centre documents were prepared to direct health communication regarding COVID-19 (USAID, 2023).

The COVID-19 communication protocol offered regional health offices the opportunity to design contextualised health communication in response to the situations in the respective regions. Hence, the Southern Nations, Nationalities and Peoples' Region (SNNPR) health office communication experts designed health messages based on their context and publicised these in all possible ways as recommended in the communication guide.

The National Communication Protocol for COVID-19 document also directs regions' health offices to implement inclusive, participatory, and persuasive health communication to build trust and to create mutual understanding. To avoid confusion, professionals who undertook training on COVID-19 were to communicate information about COVID-19 as the document instructs. Schiavo (2013) and Gamhewage (2014) explain that trust and respect are crucial for communication practitioners, health professionals and their intended audiences since trust and respect directly affect the communication process.

### **Media Integration and Convergence for Health Crisis Communication in Ethiopia: The Case of COVID-19**

Employing integrated multiple communication platforms was the main communication strategy to raise the public's awareness about the general health problems and was used for the prevention of COVID-19 expansion in Ethiopia in general and in the SNNPR in particular. Communication experts in the health bureaus made strong efforts to make health messages as simple as possible for society to understand, as recommended in the National Communication Protocol document.

The health messages were communicated through contextualised communication platforms, which suited the situation. The Communication Department of the Health Office

used a combination of traditional, interpersonal, mass media and digital media. Furthermore, print, broadcast, and online media were used to reach various groups in Ethiopian society. Blowing the *Horn* was one form of indigenous communication that was used. Traditionally, the horn is used to alert the public at the time of emergencies, such as the death of someone, and it was used to alert the public during COVID-19. This health communication practice corresponds with Ilwoo Ju et al.'s (2023) conclusions that integrated health communication significantly enhances the effectiveness of health messages. Their research demonstrated that mass media and interpersonal health information work synergistically, creating a sequential effect that motivates consumers to seek additional health information.



**Figure 2:** Image of traditional brass horn used in Ethiopia. Source: Amazon.com (2024)

## **The Influence of Interpersonal Contexts during Health Crises**

Within the interpersonal contexts, celebrities, well-known and respected people in Ethiopian society also participated in the process of disseminating health information. The broadcast media have been transmitting health messages about COVID-19 in all the broadcasting languages. Health extension workers have also participated significantly in diffusing health communication at the time of the COVID-19 pandemic. Understanding their power, the health bureau

involved opinion leaders and change agents in disseminating health communication, especially at the time of the COVID-19 pandemic. Prominent artists, politicians, authorities, and social institutions such as *Eder* and *Iqub* were used. In Ethiopia, *Eder* or *Idir* (Amharic: እድር), is a social institution used for mutual aid, and grants cooperative insurance within a specific community, while *Equb* or *Iqub* (Amharic: እቁብ) is an association of people in Ethiopian culture, formed with the aim of mobilising resources, specifically finances, that they distribute amongst members using a rotational system, that involves a form of rotating savings and credit association (Karafo, 2017). These associations may be temporary or permanent in the case of *Iqub*, or longstanding in the case of *Eder*. Traditional social institutions such as these participate in diffusing health information in general and were involved in the dissemination of information about COVID-19 in particular. Schiavo (2013) argues that health communication programmes evolve from what communication experts had originally devised due to the input and participation of key opinion leaders, patient groups, professional associations, policymakers, audience members, and other key stakeholders.

### **Tools for Health Communication and Message Content**

The Communication Department of the Health Bureau also used different tools of communication and various technologies to reach different groups of the public. Banners containing health messages were hung in public spaces and vehicle announcements were made at public gatherings, such as marketplaces and bus stations. As the health communication protocol recommends, health information should be accurate, clear, simple, understandable, inclusive, and coordinated in order to avoid an unintended communication crisis (MoH, 2020b). This concedes with Uduak Udoudom et al.'s 2023 findings that clear and targeted messaging, informed by the latest research and tailored to the needs of diverse communities, empowers individuals to make informed health decisions, adopt healthier lifestyles, and engage in preventive measures.

Hence, the health office made the messages as simple as possible. The languages and expressions used were also appropriate to society. All native languages in the relevant areas were used in national and local broadcasting and print and also in the online media to transmit health messages in general and messages about COVID-19 in particular. Ethiopia has over 89 languages and approximately 200 dialects, with Oromo, Amharic, Somali, Tigrinya and Afar forming the five official languages of the country (Tirosh, 2024). During the COVID-19 pandemic, health-focused messages broadcasted through national and regional radio and TV channels, encompassing both public and private media collectively reached an estimated 25 million people in Ethiopia, across all media outlets (Nandita Kapadia-Kundu et al., 2023).

The broadcast media (especially the local media) gave more than 50% of airtime to transmit health information about COVID-19 at the time of the outbreak. Furthermore, health professionals marched in the main streets of different towns holding placards alerting the public to the various ways of preventing the spread of COVID-19.

Opinion leaders play a significant role in diffusing new ideas in society. They lead the formation of attitudes, public knowledge, and opinions. These groups help the people to form opinions on various issues (Weimann, 2008). Therefore, communication experts understand the importance of the opinion leaders and change agents and they use them in the process of diffusing health information about general health problems and COVID-19 in particular. Likewise, brochures, flyers, and leaflets were dispatched until the office decided to stop physical contact.



Figure 3: Health Professionals' March

### የኮሮናቫይረስ በሽታ (ኮቪድ-19) ምንድን ነው?

የኮሮናቫይረስ በሽታ (ኮቪድ-19) ከቀላል እስከ ከባድ የመተንተን እኩል ሕመም የሚያስከትል በሽታ ነው። ይህ ቫይረስ እንደ ጉንፋን ዓይነት ቀላል ማልክቶችን እንዲቆጠር ሊያደርግ ወይም በሽታው ለባባስ እና እንደገና ሞት (PNEUMONIA)ጠካላ የመተንተን እካተት ሕመም ብሎም የኩላሊት ስራ ማፅዋት ሞትን ሊያስከትል የሚችል እና በዓለም ላይ በከፍተኛ ፍጥነት እየተስፋፋ የሚገኝ በሽታ ነው።

### የኮሮናቫይረስ በሽታ (ኮቪድ-19) እንዴት ይተላለፋል?

በሽታው የተመዘገቡ ሰዎች በሚያስለቡትና በሚያስጠጡበት ጊዜ ከጉንፋን ጋር የሚወጡ እርግጥነት አለባቸው ወይ ሆኖ ለሌሎች ሰው በአፍና እርንጫ ለገቡ፣ ከታማሚ ሰው ጋር ጎንኩ ካደረጉ ለምሳሌ ከተጨባጭነት ወይም ከአፍና እርንጫ ረብሻ ጋር ጎንኩ ያላቸውና ያልታጠቡ እጆቻችንን ከሌሎች በገሰገሰ ለገሰገሰ እንደ ዓይን፣ እፍን እና እርንጫን በመጎንጎት እና ያልበሉ የእንስሳት እና የሃሳ ምግቦችን በመመገብ ይተላለፋል።

### የኮሮናቫይረስ በሽታ (ኮቪድ-19) ምልክቶች ምን ምን ናቸው?

የኮሮናቫይረስ በሽታ የታየው ሰው ከኩላሊት ስራ የተጎደበ ማጠር ለመተንተን መቻላቸውን እና የአፍና ለመምጣት ምልክቶች ይታያሉ። ለባባስ ለገባቸው ሰዎች የኩላሊት ስራ ማፅዋት ሞትን ሊያስከትል ይችላል።

### የኮሮናቫይረስ በሽታ (ኮቪድ-19) እንዴት ማከላከል ይቻላል?

-  እጅዎን በውሃና በሳሙና አዘውትረው ይታጠቡ ወይም አለባቸው የሄርም ማጽጃ /ጣታይዘር/ እጅዎን ያጽዱ።
-  ባለ እና ማስጠበቅ ካለባቸው ሰዎች ስንገላ በ 2 ሜትር ወይም በ 2 ኦርምዲ ይራቁ።
-  እጅዎን ለይታጠቡ አይጎደዩ፣ እጅዎን እና እርንጫዎን አይጎደዩ።
-  ሰዎች በሚጠብቁበት ቦታዎች አይሄዱ።
-  የእጅ መጨባጠን ያቁሙ።
-  ያልበሉ የእንስሳትና የሃሳ ምግቦችን አይመገቡ።

### የኮሮናቫይረስ በሽታ ምልክቶች ምን ምን ናቸው?

- ባለቸኳይ ጠጻ የስልክ መስመር **8335** ላይ በመደወል ማሳውቅና የህክምና እርዳታ መጠየቅ።
- የህክምና እርዳታ ሰጪ ሰዶን እስኪደርስ እራሳችንን ከሰዎች በመለየት እና በእንደ ክፍል ውስጥ ለብቻችን መቆየት።
- በምናስጠጡበት እና በምናስለቡበት ወቅት እፍንና እርንጫን በሰፍት ወይም በከንድን እጥፍት መሸፈን።
- የተጠቀሙበትን ሰፍት ክዳን ባለው ቆሻሻ ማጠፋቀሚያ ውስጥ ማስወገድ።
- የቆየንባቸውን ክፍሎችና የኮሮናቸውን እጃቸውን በደምብ በሳሙናና በውሃ ማፅዳት።
- በየቦታው አለመጎደብ።

ለበለጠ መረጃ  
በባን የስልክ  
መስመር

8335

ይደውሉ።

Figure 4: A flyer consisting of messages about COVID-19 and prevention methods in Amharic

## The translation of the messages on the flier

### What is Coronavirus (COVID-19) Disease?

COVID-19 causes a disease from simple to severe that affects the breathing system. The symptoms are similar to the common cold. It may heal by itself or may develop into pneumonia and cause kidney failure and death. The virus is expanding very rapidly in the world.

### How is COVID-19 transmitted?

When an infected person sneezes, through the vapour, the virus can enter the eyes, nose and mouth of the healthy. Handshake and physical contact with infected person. Sharing unclean or unwashed objects with the infected person.

### What are the symptoms?

Fever, cough, difficulty of breathing and throat illness. If it gets severe it causes pneumonia, kidney failure and death.

### How is COVID-19 prevented?

Wash your hands frequently or use alcohol and sanitiser to clean your hands  
 Keep two metres physical distance away from persons who sneeze and cough  
 Don't touch your eyes, nose and mouth without washing your hand  
 Don't go to public places and public gatherings  
 Stop using the handshake  
 Don't eat uncooked animal and fish products

### What should we do when COVID-19 symptoms are observed?

Make a free call to 8335 immediately, describe your situation and ask for medical support  
 Until the emergency team comes to you, isolate yourself in a room  
 When you sneeze and cough use tissue-paper or your arm to cover your nose and mouth, carefully  
 Dispose of used tissue – papers carefully  
 Clean the rooms in which you isolated yourself carefully  
 Don't spit everywhere  
 For more information call on the free line 8335

## Communicating about COVID-19 using online media



**Figure 5:** Pictures used during the online campaign

The health communication bureau uses an online platform to reach the digitally literate group of society. The office spreads health information about general health problems and COVID-19 on the website and official social media accounts, such as Facebook, to share real-time information about new cases, daily recoveries, and death tolls. The Region and Zones Health Office uses Telegram to share information amongst professionals and internal staff.

Moreover, messages that promote the use of face masks, hand-washing and keeping physical distance were frequently released online. Campaigns aimed at alerting the public to

dangerous forms of behaviour were organised on Facebook and Twitter, with the motto, “*Don’t be the reason!*” [*Mikeniyat Alihonem*] “ምክንያት አልሆንም”. The campaigns were unidirectional, and messages were frequently released, but they were not interactive and did not engage the public effectively.

The situation demanded more than information exchange, as knowledge alone is not sufficient in organising a campaign to bring about behaviour change. People’s attitudes, perceptions of norms, motivation and the ability to understand the desired behaviour are key to initiating observable change (Lagarde & Banks, 2007; MAP, 2008).

Health communication during the COVID-19 pandemic urged to develop social media content to communicate accurate information to the public and tapped into existing and new platforms such as websites, Facebook, and Twitter pages of the MoH, EPHI, and Regional Health Bureaus to post daily COVID-19 updates (Nandita Kapadia-Kundu et al., 2023).

At the time of the COVID-19 pandemic, the infographs dispatched were the same and taken from similar sources, i.e., the Ministry of Health and Public Health Institute of Ethiopia. The communication would be more successful and salient to the situations if the infographs were contextualised and adapted according to the local area. However, the lack of well-trained communication experts prevented the office from doing this.

In addition to the health messages, the national and international news about the COVID-19 pandemic was frequently released on the region’s health bureau’s website and official social media accounts to educate, alert and warn the public. Two hundred and sixty Facebook posts and ten news stories were collected from the region’s health office bureau Facebook page and website.



Figure 6: Messages to alert the public about COVID-19

The SNNPR’s health office uses the website mainly to publicise public relations activities. Most of the stories on the websites focus on what the office has been doing to prevent the expansion and to reduce the socioeconomic impacts of COVID-19. The region’s health office as well as respective zone health bureaus, together with stakeholders, rigorously work on collecting resources, such as foodstuffs and cleaning materials to support the needy. In the first months of the outbreak, the health office distributed resources.



**Figure 7:** Snapshot of the SNNPR health office website in the first days of the outbreak

Banners and billboards consisting of texts and pictorial messages about the symptoms, transmission, and methods of prevention were used to alert the public. Banners were hung in public spaces and at the premises of business organisations like hotels and public service providers. Nevertheless, the height of the billboards was not up to the standards recommended. Achien’g argues that the messages on billboards and banners must be clear, concise and attractive. They should be as clutter-free as possible and easily digested in two to four seconds (Achien’g, 2009). By contrast, the banners and billboards were full of text and very short in length. The colours were not attention-grabbing. Siddiqui (2016) stated that the size of the banners, the location of the post and the contents are very important. However, some of the banners were hung on walls and were not easily visible (Siddiqui, 2016).



**Figure 8:** Banner and billboards used to communicate about COVID-19

Scholars also stress that well-coordinated and efficient communication strategies help stakeholders to define risks, identify hazards, assess weaknesses, and promote community resilience by increasing the capacities to cope with difficulties (Moreno et al., 2020).

### **Challenges for the Implementation of Health Communication Strategies in Ethiopia**

The implementation of health communication was constrained by various challenges. As identified from the empirical evidence, the lack of well-trained communication professionals, scarcity

of logistics, public negligence and neutralising the health risk become challenges for the successful implementation of health communication in general and in relation to COVID-19 in particular.

### **Lack of Communication Resources and Professionals**

Despite the attempts to make the process of communication smooth and effective, the health office faces serious challenges due to the lack of well-trained communication professionals to contextualise and implement the designed health communication. In order to alleviate this problem, the office uses volunteers to support the office's communication activities. Nevertheless, the shortage of trained communication personnel remains a challenge for the health office.

This problem was also noticeable during the public announcements and in the use of graphics materials online. Until the release of the Communication Protocol document, public opinion leaders described COVID-19 as: "*the virus originated from China*", "*China virus*", "*horrific virus*", "*terrifying virus*", "*deadly virus*" and "*the killer virus*" to alarm the public. However, these expressions are regarded as inappropriate and incorrect in the Communication Protocol developed later. Moreover, public misconceptions about the virus were pervasive. Many people believed that COVID-19 was "the bad spirit 666," which negatively affected preventive practices (Nandita Kapadia-Kundu et al., 2023).

Since COVID-19 was a new phenomenon in the medical arena, medical experts faced challenges in giving timely and accurate explanations about the nature and characteristics of the virus. Health communication experts explained that this knowledge gap was an obstacle in preventing the spread of COVID-19. Hence, health communication officers used the Internet, especially the WHO's website, to get updated information about COVID-19.

## Logistical Problems and Public Negligence

Logistics is also regarded as a challenge for health communication activities in general and COVID-19 in particular. The context, i.e., a large geographical area and large population with high demand for universal health coverage, requires adequate logistics. However, the economy cannot afford to provide the required logistics and incentives to the health professionals and stakeholders.

Regarding COVID-19, stressing its dangers was an important way to teach the public how to use prevention materials like face masks, and activities like hand-washing. However, these materials were not supplied in adequate quantities, and communication teams were therefore not able to use them in demonstrations. The negligence of the public was a serious challenge during the COVID-19 pandemic. The goal of health communication is to bring about behaviour change, but changing public behaviour was not as easy as expected. The public acquired adequate knowledge about preventing the transmission of COVID-19. However, it did not apply the preventive measures as recommended by Peretti-Watel (2003).

The public did not adequately adopt COVID-19 prevention protocols and rationalised this neglect using different reasons. Some believe that keeping themselves safe from the risk of COVID-19 is beyond their capacity. Some believe the conspiracy theory that COVID-19 is a disease to harm developing countries. Others have the confidence that God protects them from the dangers of COVID-19. Some groups compare the disaster that COVID-19 wrought on Western countries with the limited impact on Ethiopia and consider it a normal health problem. This rationalisation has made the public negligent about COVID-19 prevention a negligence that has been observable at coffee houses, bars and restaurants and in their conversations with friends. Neutralisation or drift does not “cause” dissonance in the positive sense; rather, drift makes delinquency possible (Maruna, 2005). As widely recognised, bridging the gap between knowing and doing is challenging; the intention-behaviour gap is well-documented. Awareness does not always translate into action

(Arnstein Finset et al., 2020). As a result, society has become vulnerable to the risks posed by COVID-19.

## **Public Perception of COVID-19 Isolation and Treatment Centres**

The public perceived isolation and treatment as a detention centre. As a result, people were terrified that being found COVID-19-positive would mean detention in such centres. They were not willing to stay in the centres and used any opportunity to escape. The public's perception of isolation and treatment centres was thus yet another challenge with regard to COVID-19.

A tragic example was a woman, who showed symptoms of COVID-19, being taken to a centre until her result was known. From the beginning, she was not willing to enter the isolation centre. After she entered the isolation centre, she committed suicide, locking her room before her laboratory test result was known. Unfortunately, her result was COVID-19-negative. The incident was shocking for the team working in the centre, and a mental health unit was then established in the isolation and treatment centres to give counselling and guidance for the people staying there (Hailu Shibiru, personal interview, 2020).

Arnstein Finset et al. (2020) emphasised the importance of recognising the mental health impacts of prolonged social isolation on vulnerable individuals. Additionally, Jessica Hemberg et al. 2024 found that many people, youths and adults, were victims of fatigue and were depressed due to isolation. The situation made them to feel like outsiders. Baquerizo et al. (2024) further discussed that isolation created loneliness that disconnected friends and families. This communal sense of isolation during the COVID-19 pandemic aggravated the existing family dynamics of social disconnection. The situation reduces students' proactive factors enhancing suicidal ideation. A significant number of people considered attempting suicide. This suicidal ideation is a national crisis amongst the youth.

## Lessons to Learn about Health Communication in Ethiopia

Health communication in Ethiopia has achieved tremendous success in diffusing health information amongst society due to the use of multiple and coordinated communications channels. Moreover, the traditional social institutions like *Ider*, *Ikub* and religious centres where people gather for social causes have leaders (opinion leaders) who have been significantly involved in the process of health communication. Health extension workers as change agents have also played an enormous role. Rogers described a change agent as an individual who influences clients' innovation decisions in a direction deemed desirable by a change agency; they are often professionals with university degrees in technical fields, and they use opinion leaders within a given social system as lieutenants in diffusion campaigns (Rogers, 1983).

Contextualised health communication strategies and training also enable change agents to become acquainted with the situation in which they are working. In most of the regions, opinion leaders and change agents have passed through intensive training programmes and they have identified bottlenecks that impede the implementation of health education programmes in their villages. Identification of cultural and attitude-related bottlenecks is crucial and needs emphasis (Wang et al., 2016). Furthermore, health extension workers are major sources of health information and health service provision, including antenatal care, family planning, and general outpatient service (fever and diarrhoea treatment), and it is the most important intervention undertaken by the government of Ethiopia (Wang et al., 2016).

The assumption behind the health extension worker model is that if the right health knowledge and skill are transferred, households can become responsible for maintaining their own health (Caglia et al., 2014). Therefore, health extension workers have brought significant achievements in community-based care, building trust in the system, maintaining health quality and saving lives. Moreover, health communication and education have brought about remarkable changes in combatting the health

problems of society. As studies have identified, malnutrition, health status, knowledge about fertility, knowledge about sexually transmitted infections (STIs), early pregnancy, child marriage, literacy, numeracy, even education enrolment have been definitely changed in society (Rudgard et al., 2022; Caglia et al., 2014; Wang et al., 2016). Health education in Ethiopia has influenced the community's view and made the community responsible for their own health, which is the desirable outcome of health communication. However, challenges identified by prior studies (Caglia et al., 2014), such as limited training opportunities for health extension workers, poor working conditions at health posts, and limited supervision, hinder and reduce these workers' ability to provide effective focused health communication in Ethiopia.

Other countries can adopt the Ethiopian model to implement successful health communication. All training resources are available free of charge and adaptations for other contexts are encouraged (Caglia et al., 2014). The strategies that Ethiopia has implemented in health communication is exemplary in the region. Other countries in the region or elsewhere can take a lesson from Ethiopia's health extension packages, particularly from health communication in community mobilisation and empowerment, political commitment, and coordinated national policies, into their context.

An insight, here, is that the collaboration between the social and state actors on the issue of health problems and health communication should be strengthened and promoted in order to be adopted in other areas to alleviate the deep-rooted socio-economic problems of the society.

## **Conclusion**

A well-defined health policy, which acknowledges the importance and necessity of health communication, which considers the fast-growing economy and large population numbers, has been implemented to raise the public's consciousness about health problems in general and specific health problems like the COVID-19 pandemic. Depending on the contexts and health

problems, decentralised health communication is implemented. Therefore, health communication provides the public with the necessary health information, raises the consciousness of members of the public about health problems, and makes them responsible for their own health. The spread of COVID-19 necessitated accurate, credible, pertinent and timely health information to keep the public calm and avoid panic due to information overflow. The communication department addressed the information needs of the public accordingly.

In order to disseminate health information successfully, various types of media were employed and different groups of people (change agents and opinion leaders) participated, and significantly supported the communication process, as the Diffusion of Innovations Theory model explains. However, the public cannot apply all the recommended means of prevention due to circumstantial and social challenges, and, as the neutralisation theory describes, members of the public also attempt to justify their lack of compliance. Though health communication in general, and in relation to COVID-19 in particular, has been challenged due to various factors, it has encouraged members of the public to be responsible for their own health, which in turn lends considerable support to universal health coverage in Ethiopia.

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## Chapter 3

# Decolonising Health Communication Strategies: The Inclusion of Traditional Healers from Sub-Saharan Africa into Multi-Sectoral Health Crisis Communication Interventions

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### Abstract

Traditional healers form one of the most influential voices amongst rural and increasingly urban populations in several sub-Saharan African countries. They offer great potential for effective multi-sectoral, health crisis communication interventions in sub-Saharan African countries. Yet they are often excluded by policymakers when health problems that affect their stakeholders are formulated. When crises escalate, however, it appears that they are invited to partner with policymakers in multi-sectoral interventions meant to find effective solutions. This belated inclusion of traditional healers by policymakers is unfortunate because effective multi-sectoral health interventions should involve all relevant stakeholders from the conceptualisation stage. Globally, most countries follow a biomedical paradigm of health practices also referred to as Western, mainstream or conventional medicine. It is inevitable then, that biomedical health practices have a dominant influence on the conceptualisation of health crisis communication strategies, while alternative approaches are marginalised, thus leading to the exclusion of divergent approaches. Theoretically, decolonisation of health crisis

communication strategies in sub-Saharan Africa would advocate for the involvement of traditional healers, given that traditional healers exert a strong influence on the well-being of their clients who often prioritise them in their health-seeking behaviour. Most African populations in sub-Saharan Africa make parallel use of traditional / alternative and Western medicine. Such health-seeking behaviour should inform reciprocal actions by policymakers to ensure equity of participation especially during health crises when reaching the largest possible percentage of the population is critical, through promotion of divergent approaches.

### **Introduction**

Multi-sectoral health interventions have proved to be effective as health crisis communication strategies in Africa. Multi-sectoral approaches are integrated collaborative processes that involve various stakeholders to address complex challenges and interrelated goals that relate to public healthcare (Fox, 2014; WHO, 2016; Brinkerhoff et al., 2017; Lubinga & Sitto-Kaunda, 2024). Even then, these multi-sectoral health interventions have not always considered traditional healers (THs) as important or viable co-formulators of health communication strategies. Studies show that the use of traditional medicines are the main source of healthcare for mental illnesses in Uganda and that patients with AIDS (acquired immunodeficiency syndrome) symptoms in Malawi, South Africa, Uganda and Zimbabwe have used traditional medicine (Kasilo et al., 2019). In the past, during epidemics and pandemics, well-designed communication strategies have faced implementation obstacles, including failure, because policymakers were unable to secure the collaboration of the masses of people that health interventions are meant to benefit. But there is clear evidence that epidemics and other health problems in Africa, including human immunodeficiency virus (HIV) and AIDS, tuberculosis (TB), malaria, cholera, psychiatric conditions and other diseases, have greatly affected populations, especially in the poorer communities (Mokgobi, 2013).

Typically, what happens during crises is that health communication strategists turn to THs in order to engage the mostly rural masses as part of alternative health communication

only when strategies with other communicators have not been successful. The routine exclusion of THs in health communication in sub-Saharan Africa is a consequence of health authorities following a hegemonic biomedical paradigm. Given that the majority of people in sub-Saharan Africa frequently turn to THs – especially during crises – this approach should be rethought. Decolonisation can be achieved only if an African approach to doing things is strategically combined with existing biomedical practices. This paradigm should be considered by policymakers as part of a multi-sectoral crisis health communication strategy.

The lack of optimal buy-in into health communication strategies when crises arise, especially by rural populations in sub-Saharan Africa, may be caused by the failure of policymakers and implementers to include socio-cultural stakeholders as co-creators of these strategies. Socio-cultural stakeholders, specifically THs, have the potential to reach hitherto inaccessible audiences in Africa's mostly rural communities. As already pointed out, during times of epidemics and pandemics, many Africans use a combination of Western and traditional medicine, with the latter sought first.

Having established that policymakers should include THs to partner with during the formulation of health crisis communication strategies, the question that then arises is how they can be involved and how existing perceptions amongst policymakers can be changed. These problems may also be exacerbated by poor legislation in some sub-Saharan countries affecting when and how THs participate in health interventions.

### **Contextualising Traditional Healing and the Health-Seeking Behaviour of Sub-Saharan Africans**

Many Africans in general, and sub-Saharan Africans in particular, habitually engage in health-seeking behaviour that involves the use of traditional medicine, with some routinely consulting with THs. For instance, in Ghana, it appears that up to 70% of patients use traditional or herbal medicines with some health facilities reportedly initiating the use of herbs as part of healthcare delivery (James et al., 2018). THs, who abound in both rural

and urban areas of sub-Saharan Africa, have provided health services over centuries, a clear indication of how effective their practice is to users. Even though traditional healing has for many years been most popular in rural areas, the migration of African populations from rural to (peri-) urban areas has ensured that the health-seeking behaviour is carried over to and sustained in new migration settings (Mokgobi, 2013). Furthermore, the recent proliferation of e-traditional healing propelled by popularisation through digital as well as social media has ensured a wider reach and sustainability amongst both urban and rural Africans. Africa remains a largely rural continent.

A 2020 report by the Organization for Economic Co-operation and Development (OECD), *Africa's Urbanization Dynamics 2020: Africapolis, Mapping a New Urban Geography* (OECD, 2020) indicates that Egypt and Libya in North Africa are the most urbanised countries in Africa, at 93% and 81%, respectively. On the other hand, there are over 20 sub-Saharan African countries with less than 40% urbanisation levels. In 2020, urbanisation in East Africa (Rwanda and Burundi), Southern Africa (Malawi) and West Africa (Niger) was below 20%, with Niger at 17%, Burundi at 21%, and Eritrea at 24%, representing some of the lowest levels of urbanisation in sub-Saharan Africa. Within the context of a mostly rural continent, to most sub-Saharan African citizens, socio-cultural relationships are crucial for informing and guiding behaviour, including health-seeking behaviour. In sub-Saharan African countries, 80% of the population purportedly rely on traditional medicine for their health needs (Renckens & Dorlo, 2013). Mushebenge et al. (2021) posit that THs, also termed as traditional health practitioners (THPs) are more accessible to the populace, with a significantly higher proportion of THPs (1:500 persons) than conventional medical practitioners (1:40,000 persons). Furthermore, the use of traditional medicine may involve in-person consultations, or more recently, the increasing phenomenon of virtual consultations with THs.

Therefore, THs are important stakeholders forming the socio-cultural fabric of African communities. And given that communication is an integral part of influencing health-

seeking behaviour, the people who communicate such messages matter, as they affect prevailing perceptions and cultural beliefs. Cultural-oriented health theories such as Pen 3 Cultural Theory by Airhihenbuwa (1989) have proved the importance of culture in influencing the behaviour of individuals.

Given that Africans routinely seek the help of THs, in some contexts they have proved to be successful communicators in multi-sectoral health interventions. For example, in Uganda, a study on the use of THs to influence HIV testing found that the delivery of point-of-care HIV tests by THs to adults of unknown serostatus significantly increased rates of HIV testing, with 100% of patients being tested in an intervention group (Sundararajan et al., 2021). The parallel health-seeking behaviour of sub-Saharan Africans involving both traditional and biomedical medicine proves that the former is trusted and considered to be as effective as the latter. In countries such as Cameroon, prevailing tropical diseases such as human African trypanosomiasis (sleeping sickness), Buruli ulcer, and snake bites have been investigated and managed by THs, with reports that in Central Africa, in general, more than 80% of the patients seen in hospitals first consulted a TH (Nolna et al., 2020). Similarly, Abbo (2011) reported that over 80% of patients with psychosis used both biomedical and traditional healing systems and that those who combined the two systems seemed to have a better outcome. This practice, which indicates high levels of trust in traditional medicine by African populations, is driven by word-of-mouth exchanges by users in interpersonal communication contexts between THs and their clients.

### **Health is a subjective construct**

Perceptions, especially in health, remain subjective constructs which cut through segments of society illustrating differences in backgrounds and frames of reference. Health is also defined differently depending on whether it is defined by health professionals or patients. Therefore, by definition, the health concept rests on an individual perspective on health and illness (Souto et al., 2018). From a patient's point of view, health refers to the ability to live expressed in a state of health (Krabbe, 2016).

Perception is a process in which the individual organises the sensory stimuli into meaningful information (Hamlyn, 2019; Ross, 2010). According to Crown (2012), health perceptions encompass both physical and mental well-being and, for some, even spiritual attainment. Souto et al. (2018:2186) state that health perceptions are personal beliefs and assessments of the general state of health that show how people consider themselves to be well or not, and an individual's perceptions can reflect feelings and beliefs that extend beyond their current physical state. Such subjectivity extends to the decisions that people make, regarding whether to use services of THs or not.

In Africa, traditional healing exists in parallel with biomedicine and continues to play an important role in primary healthcare for many Africans. While traditional healing exists as an accepted form of healthcare in Africa and other parts of the world, it varies greatly across different countries and regions because they are influenced by factors such as culture, personal attitudes and patient health information (Zhandire et al., 2021). Gyasi et al. (2011) argue that although traditional healing appears to be embedded in the personal preferences, values, religion and philosophies of people, its development should not end up in political polemics; rather, real, concrete and interactive action should follow the recognition of the contribution of traditional healing to the healthcare of people. Given the sheer variety of personal values and religion as well as the philosophies of people, perceptions on traditional healing as a practice and THs as practitioners will most likely differ.

### **Mixed Perceptions Towards Health in Diverse Sub-Saharan Contexts**

#### **Trust and authenticity in Sierra Leone**

The health-seeking behaviour of sub-Saharan Africans involving consultation with THs is greatly informed by their beliefs as well as their experiences. These populations have relied on centuries of interpersonal interactions with THs and often compare

communication between biomedical health personnel with experiences with those of THs.

For instance, during the 2014 to 2016 Ebola epidemic in Sierra Leone, people chose to consult with local THs whom they knew and trusted when the health crisis peaked, due to negative rumours about medical personnel (Dziewanski, 2015). Several Sierra Leoneans reported negative experiences about “rude or unhelpful medical staff in clinical settings that they found to be intimidating and unfamiliar” (Dziewanski, 2015).

### **Perceived commercialisation of health in the Democratic Republic of Congo (DRC)**

In the Democratic Republic of Congo (DRC) the local people believed that the spread of Ebola was driven by commercial benefit, specifically that it was a result of business actions during the DRC’s tenth Ebola outbreak in Kivu (MSF, 2020). This led to attacks on health centres, threats and murder of healthcare workers (Muzembo et al., 2020). Their study revealed several negative perceptions by local people about the spread of the disease, including the fact that Ebola was interpreted as a plot by multinational corporations. Local people believed and feared that it was created as a tool for genocide; it was perceived to be a biological weapon. People expressed concerns over organ trafficking during the Ebola epidemic. In addition, Ebola was rumoured by people to be subject to politicisation. Political leaders were perceived by populations to be ambivalent, especially through the exclusion of some community leaders from response efforts. These actions by political leaders led to distrust of political authorities by the public as well as distrust in the healthcare system (Muzembo et al., 2020).

### **Mistrust and othering in South Africa and Ghana**

It can be argued that general perceptions of health and what is considered a legitimate health provider are represented by an integration of various definitions of health by different stakeholders in society and these health definitions and perceptions have a bearing on health behaviours. Studies by

Goodwin and Engstrom (2002) and Zahrt and Crum (2017) in the United States (US) found that health perceptions are an important indicator of health outcomes. In this case the perception of traditional medicine and THs will also depend on how it is defined by the stakeholders in society, including patients who sometimes consult THs. In South Africa, De Andrade (2011) reported that there appears to be a perception that THs are more attuned to people's needs and that "they fit the psychology of our people". For their part, Van Niekerk et al. (2014) found mutual mistrust between allopathic and THs. On the other hand, in Ghana, Gyasi et al. (2011) perceived traditional medicine as readily available to the people and less expensive, hence easily accessible. Hlobano (2013) revealed that in South Africa, THs experienced mistrust and disrespect by biomedical health professionals, who demonstrated ignorance towards traditional medicine. Gyasi et al. (2011) propose policy options that seek to address some of the difficulties and challenges encountered by the practice of traditional medicine and improve the quality, safety, and standard of service.

Furthermore, Nkosi and Sibiyi (2018) found that in South Africa, THs referred patients to the hospital, but radiation oncologists did not reciprocate (there was no referral from the radiation oncologists). They reported that both parties value cooperative practice but were still wrestling with THs' own locally developed practices of traditional medicine use. In addition, in Ghana, Nyame et al. (2021) reported that underlying the widespread approval of forging partnerships, there were mutual undertones of suspicion. While primary healthcare providers were mainly concerned that THs cause harm to service users, service users and their caregivers highlighted the failure of conventional medical care to meet their healthcare needs.

### **Theory**

A number of theories could underpin the argument for the inclusion of THs in the conceptualisation of health crisis communication strategies. This chapter proposes decoloniality, Africanisation and culture-centred approaches (Dutta-Bergman, 2004; Dutta 2007).

Decoloniality as a theory is described as a family of diverse positions that share a view of coloniality as the fundamental problem in the modern age and not as a singular theoretical school of thought (Maldonado Torres, 2011). A number of Global South scholars argue that the core argument of decoloniality is premised on the agenda of shifting the geography and biography of knowledge – who generates knowledge and from where (Mignolo, 2007; Escobar, 2004; Maldonado Torres, 2011; Moyo, 2024). These authors from the Global South argue for the promotion of knowledge and views from their perspectives as opposed to those of the Global North / Western societies.

Decoloniality thus aims to disrupt Westernisation to open multiple other forms of being in the world (Letsekha, 2022). According to Letsekha (2022), constructing a new path of “thinking, sensing, believing, doing, and living”, involves the fact that this new path “... cannot be built with the master’s tools for the master’s tools will never dismantle the master’s house. They may allow us temporarily to beat him at his own game, but they will never enable us to bring about genuine change”.

From an African point of view, Ndlovu-Gatsheni (2015) revealed that decoloniality is borne out of a realisation that the modern world is an asymmetrical world order that is sustained not only by colonial matrices of power but also by pedagogies and epistemologies of equilibrium that continue to produce alienated Africans who are socialised into hating the Africa that produced them and liking the Europe and America that reject them.

As it applies to African traditional medicine, Ndlovu-Gatsheni’s argument (2015) can be seen to criticise the notion of undermining and separating African traditional medicine from Western medicine. This practice indirectly continues to promote ‘white supremacy’ in the design of health communication strategies. Issues of ‘whiteness’, ‘racism’ and ‘white privilege’ are components of ‘white supremacy’ and are associated with the political power during the colonial and apartheid regimes (Mashau, 2018). Mashau (2018) refers to societal marginalisation as well as the exclusion of African solutions to African health problems by policymakers who suppress indigenous health

knowledge. Furthermore, indigenous health knowledge is often measured against biomedical knowledge, with the latter being favoured in the design of health communication strategies.

The continual use of biomedical specialists or experts as predominant sources of health solutions and as providers for health knowledge and concrete information for the design of health communication strategies in Africa speaks to the marginalisation of indigenous health knowledge. Westernised systems such as biomedical paradigms are viewed as being colonial by decoloniality theorists with their prevailing societal hegemony perceived as continuing to erode the indigenous African cultures and wisdom systems. Decolonisation is primarily a knowledge project grounded in African philosophy, which is generally tied to indigeneity, which in principle is the idea that knowledge construction and pursuit must be relevant to the context of the people (Manthalu & Waghid, 2019). On the other hand, Africanisation comprises a focus on indigenous African knowledge and concerns simultaneously 'legitimation' and 'protection from exploitation' of this knowledge (Horsthemke, 2004). Africanisation has become important to African people in their quest for unity and a sense of belonging, having pride in who they are and what they stand for. According to Louw (2010), Africanisation is the process of defining or interpreting African identity and culture; it is not a process of exclusion, but rather of inclusion. It is a learning process and a way of life for Africans. It involves incorporating, adapting, and integrating other cultures into and through African visions to provide the dynamism, evolution, and flexibility so essential in the global village.

It can be argued that Africanisation refers to conscious and deliberate decisions by policymakers to include traditional / indigenous knowledge in health communication strategies, to ensure the inclusion of indigenous health knowledge in key decision-making bodies. Africanisation in the context of decoloniality may mean embracing African knowledge and develop a sense of loyalty towards indigenous health knowledge through its adoption and promotion for health communication strategies, ensuring equity with Western solutions. In relation to this argument, during the Coronavirus disease 2019 (COVID-19)

pandemic, South African National Co-ordinator of the Traditional Healers Organisation, Gogo Maseko (IOL, 2020) argued that society shuns traditional medicine, with “the worst culprits being medical schools, media houses and religious institutions, that have been colonised for far too long, and look down on every traditional or indigenous cultural practice that might empower Africa’s people.”

For users of both biomedical and traditional medicine, the interaction between these two worldviews is complex and results in cognitive conflict. Yet, Africanisation as a legacy should enable a connection with broader African indigenous knowledge and the establishment of indigenous health solutions that bind Africans together (Louw, 2010). This should be done to confront the sense of ‘Africanness’, transcend the individual identity by seeking commonality, recognising and embracing African otherness. The inclusion of indigenous health knowledge for health solutions during the designing of health communication strategies is one way of understanding Africanisation as a move towards an understanding of African contexts and the socio-economic realities of the African people.

Considering the diversity of the African context, Africanisation implies concentrating efforts on obtaining new insights and developing new praxis on the contextual realities of the beneficiaries of services within a specific context (Van der Westhuizen & Greuel, 2017). Africanisation would require the development of health communication strategies that are African-related, reflecting indigenous health solutions. This does not mean that policymakers should focus solely on the development of new decolonised health communication strategies, but that they should effectively include African indigenous knowledge in the designing of health solutions. This move would involve multicultural and multi-sectoral health communication strategies that provide insight into and exhibit understanding of African contexts.

## **A culture-centred approach**

Dutta's culture-centred approach examines the voices of marginalised groups and explores the interaction between culture and structure that create conditions of marginality (Dutta-Bergman, 2004a, 2004b; Dutta, 2007). This theory argues for the inclusion of subaltern classes that have traditionally been marginalised and are absent in dominant theories and models (Dutta, 2011). Most of the behavioural change theories that have predominantly informed health communication, such as the health belief model, theories of planned behaviour, and the theory of reasoned action, have neglected the importance and influence of culture as well as representatives of indigenous health knowledge such as THs. Dutta posits that the culture-centred approach necessitates working from within, where cultural members actively participate in defining problems and developing solutions (Dutta, 2007, 2011). Culture is a communicative process by which shared meanings, beliefs, and practices are produced (Geertz, 1973) as well as a shared experience that is central to living and communicating for social groups.

THs also play an advocacy role. They not only communicate with their clients, but also communicate for and are advocates for their clients. For instance, during the COVID-19 pandemic in several sub-Saharan African countries, societal members who consult with THs were disadvantaged when they could not gain access to their practitioners. Specifically in South Africa, during hard lockdown, which resulted in the restriction of movement, groups of workers including biomedical doctors were designated as essential service providers and were allowed to work. THs were excluded from being provided with special travel permits even though the Traditional Health Practitioners Act number 22 of 2014, hereafter referred to as the Traditional Health Practitioners Act (South Africa, 2007), allows THs registered with the Traditional Health Practitioners Council of South Africa to issue valid medical certificates as recognised professionals to patients seeking treatment based on traditional beliefs (Nzimande et al., 2021; Tshela, 2015). During the COVID-19 pandemic, traditional healers pleaded with the government to be allowed to support the fight against COVID-19 (Beyers, 2020) because they

were not consulted by the Department of Health, even THs are officially considered as part of the government system to provide healthcare. The president of the Traditional Healer Association in the Southern Africa Development Community (SADC) region, Dr Sylvester Hlati, complained that THs and patients were left out of South African national pandemic preparations. THs were unable to collect traditional medicines and herbs from various parts of the country but also to consult with their patients (Mukwevho, 2020). THs had to protest against their exclusion from the COVID-19 consultation process before they were brought on board (Bhengu, 2020).

## Discussion

### **Factors changing the Practice of Traditional Healing for interpersonal communication in sub-Saharan Africa contexts**

#### *The growth of e-traditional healing: Ease of Access and Sustainability of practice*

The proliferation of digital and social media technologies as well as ease of access to related communication platforms have transformed the public sphere. Such technological growth has created new ways of doing things, enabling people to be within “click” reach of others. Interpersonal communication contexts involving traditional healing have not escaped the effects of digital technologies. Whereas in the past, traditional healing was limited to in-person interpersonal communication, digital technologies have facilitated virtual interactions. Traditional healing involving the use of digital technologies, virtual or e-traditional healing emerged before the COVID-19 pandemic, but this period, characterised by hard lockdowns that limited in-person consultations, accelerated the practice. As GogoOnline (2022) posits, participation in an online session with a TH is how the digital world is changing the way they communicate, because many THs are connecting with patients online, arguing that spiritual connections have no boundaries. E-traditional healing may have opened up opportunities for traditional healing that

transcend the boundaries of access to potential patients previously imposed by physical or in-person interpersonal communication.

Multiple digital and social media technologies have provided a plethora of platforms for e-traditional healers as well as interested publics. Digital media such as websites reaching broad audiences and used as a means of creating awareness about various options for traditional healer locations as well as more interpersonal social media enabling one-on-one interactions are available for public use. A case in point is 'GogoOnline', a South African website created during the COVID-19 pandemic in 2020, where interested people are able to find traditional healers located near them. Some of the THs listed on the 'GogoOnline' Facebook page have Twitter as well as Instagram accounts where interaction with clients takes place. Schütz (2021) observes that 'GogoOnline' is a database for THs to advertise their services, launched during lockdown. 'GogoOnline' co-founder and healer-in-training, Xhanti Madolo, states that while the platform may have assisted healers with accessing permits, he believes that THs' success may have been curtailed not just by the lockdown regulations but by a historical lack of recognition. The 'GogoOnline' Facebook page features numerous THs available to the public for consultation and lists their fields of specialisation. Phaliso (2021) states that with the launch of the 'GogoOnline' directory, THs and their clients can now connect digitally wherever they are in South Africa. The directory lists THs' names, location, contact details and the services that they provide. However, rapid changes in digital and social media as well as the growth of artificial intelligence (AI) mean that e-traditional healing long superseded the mere provision of TH location, contact details and services. International consultations have been in existence for a long time.

Public perceptions of THs have often been misinformed, judgemental and backward (GogoOnline, 2022). Societal and individual cultural beliefs are intrinsically interwoven with traditional healing. Traditional healing is a topic that has been sensationalised and its practice is still perceived by some people, depending on their beliefs, as not being a reputable healing form in its own right. Chigona et al. (2008) reported that the use of technology to store and share patient and treatment information

with other THs, healer associations and Western-oriented health providers, would require a major change in relationships between traditional healers and biomedical healthcare providers.

### **“Scientification” of Traditional Healing in sub-Saharan Africa: Marketing Communication for herbal remedies**

Synergising traditional healing with biomedical healthcare could be fast-tracked by recent developments in relationships between the two groups. The recent COVID-19 pandemic illustrated that traditional medicines that have over the years been considered ineffective due to a lack of scientific evidence, could prove to be effective in treatment of diseases with the commencement of clinical studies. In diverse sub-Saharan African countries, scientific trials of traditional herbal medicines commenced during the pandemic (Mutombo et al., 2023). For instance, clinical trials of herbal medicines as supplementary in the treatment of COVID-19 were either completed or were ongoing in Burkina Faso, the Democratic Republic of Congo (DRC), Ghana, Guinea, Madagascar, Nigeria (which has the only privately funded study), South Africa, United Republic of Tanzania, Uganda while Nigeria had the only privately funded study. Furthermore, clinical observational studies were conducted in Benin, Burkina Faso, Congo and DRC. In countries such as DRC, Guinea, Madagascar and Uganda, some of the traditional medicine products received marketing authorisation. Popular herbal products were sanctioned by some African governments, including high-ranking officials such as the President of Madagascar, Andry Rajoelina, for COVID-organics with *artemisia* from Madagascar (Shaban, 2020) and Uganda’s National Drug Authority endorsed a herbal medicine, *Covidex* (Athumani, 2021).



**Figure 1:** Covidex. Source: [UBC](#) (2021)

In other sub-Saharan African countries, acknowledgement of herbal remedies as supplementary alternatives to biomedical treatments took place at lower levels. For instance, in the DRC biochemists advised people to take *maniquette* or *mondongo* and vegetables including ginger, garlic and onions in addition to respecting protective measures, even while many people bought *Kongo-bololo* as herbal treatment (Nsono, 2020). The move towards scientific recognition of traditional medicines will inevitably be partially driven through communication, as

was the case with government support and marketing of herbal products during the recent COVID-19 pandemic.

## **The future of Traditional Healing in Sub-Saharan Africa**

### **Possible benefits of integrating traditional healing in multi-sectoral health interventions**

Opportunities exist to integrate THs into the pyramid of care by, for example, providing them with suitable technology to contribute to adequate patient management and transfer to other healthcare services when appropriate. It is possible to go further. With the advance of telemedicine, especially during the COVID-19 pandemic, THs could be trained and equipped with smartphones and other technology that will help them to contribute to the surveillance of epidemics and pandemics. Their integration into the formal healthcare system will both facilitate overall care provision as well as increase quality control of TH activities, as should be done with any health professional. Such regulation will limit the malpractice that is seen in many African countries, where traditionally prescribed drugs are not controlled.

Without the integration of traditional and Western medicine, patients might languish in either of the medical systems, leading to delays in care and, in some cases, death. Devising efficient schemes to collaborate with THs will make them assets in providing healthcare in our communities, instead of the liabilities they might, in some cases, be. For example, the OECD (2021) stated that a multi-sectoral, integrated approach to mental health means making mental health a priority in sectors beyond the mental health system. Good performance in mental health is not only the responsibility of mental health specialists, but rather must include a wide range of actors and sectors, including teachers and schools, line managers and workplaces, as well as other community actors. Similarly, Green and Colucci (2020) found that despite differing conceptualisations of mental illness causation, both THs and biomedical practitioners recognise that patients can benefit from a combination of both practices

and demonstrate a clear willingness to work together. It can be argued that the multisectoral approach insists on ensuring that an integrated perspective is included within the mental health system. In relation to this study, it can be argued that more could still be done to strengthen the multisectoral health interventions designed for African communities. Hence, the focus in this area of development is critical in Africa, where health problems weigh more heavily on communities with lower economic status, unemployment and so on, where an integrated health system is needed.

Mokgobi (2013) reported that the delay in integrating the two healthcare systems means that people continue to enlist the services of both modern healers and THs without realising how potentially dangerous it could be. This is especially if the two sides do not communicate about the remedies that they inadvertently and simultaneously administer for the same illness. With this in mind, the study argues that the integration of these two practices in mostly sub-Saharan countries is no longer a luxury but a necessity. De Leeuw (2017) clarified that the conceptual foundations for integral health governance, policy, and action delineates the different sectors and their possible engagement and provides an overview of a continuum of methods of engagement with other sectors to secure integration. Although there is an understanding of the necessity of both types of healing, providers may need to be pushed to reach this understanding by the institutionalisation of traditional healing by the government (Hardy, 2008).

On the other hand, the WHO (2018) revealed that many of the determinants of health and well-being – commercial, cultural, economic, environmental, political, and social – are influenced by policies beyond the health sector. Therefore, the WHO (2018) further argues that multisectoral and intersectoral action is required for effective health promotion at the local, national, regional, and global levels. This chapter argues that a multisectoral approach to health interventions may see the involvement of all health sector stakeholders, including THs. This multisectoral approach has the potential to reduce health inequalities and improve the health well-being of disadvantaged

communities. Moreover, this may tackle the inequitable distribution of power in terms of whose insights and voices carry more weight when health interventions are developed. This study further understands that achieving a balance of power by incorporating a wide range of insights and voices in health interventions development is a shared responsibility and requires the involvement of all health sector stakeholders, including THs.

## Conclusion

The health-seeking behaviour of most sub-Saharan Africans points towards the potential of THs to form one of the crucial communication pillars in health crisis communication. The recent COVID-19 pandemic forced sub-Saharan African countries to begin scientific testing of traditional medicines increasing the potential of use and acceptability by the government and public. Furthermore, tools such as e-traditional healing have enhanced and increased the means of contact between THs and their clients, escalating the potential for effective communication. We argue that THs play an important role in interpersonal health communication and migrated health practices in sub-Saharan Africa. Their current 'missing voices' in the formulation of future health crisis communication strategies should be remedied through inclusion by policymakers in multisectoral interventions. Therefore, THs could become an important part of multisectoral health interventions during future health crises.

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## Chapter 4

# Science and Health Journalists in the Health Communication Continuum: Working towards Improved Skills and Capacities in South Africa and Namibia

*Nkosinothando Mpfu* 

### Abstract

The recognition of the role of science and health reporters in the value chain of social and behavioural change communication continues to gain momentum in Africa. Recent developments in health information access have shown that health and science reporters play an important role in bridging the gap between ‘the voice of science’, the ‘voice of the state’ and the public who have to use the information in decision-making. This science communication role requires specific capacities and capabilities to repurpose and contextualise messaging and to disaggregate communication tools and platforms to reach different audiences. Although they are such important health communication stakeholders, their actual place in the health communication continuum continues to be mostly misunderstood and overlooked. This poses challenges for them in accessing the appropriate skills and capacity-building opportunities. Using a qualitative approach, this chapter explores the systemic and capacity challenges of science and health reporters during the Coronavirus disease 2019 (COVID-19) pandemic in South Africa and Namibia. The chapter argues that understanding the capacity and capability needs of science and health journalists is the starting point towards skills enhancement and more effective science and health journalism.

## Introduction

Information is undeniably a valuable mechanism that enables people to cope in crisis situations. It is a means that people can use to reduce uncertainty, anxiety, panic and chaos during a crisis (Casero-Ripolles, 2020; Cheung et al., 2023). The COVID-19 pandemic was a health crisis that brought to the fore the significance of science and health information. Given the uncertainty that surrounded the pandemic, it was imperative that reliable information about the pandemic was shared. Information on COVID-19 would focus on transmission and prevention and encourage the public to adopt measures that would curb the spread of the pandemic (Guttman & Lev, 2020; Mello et al., 2021 in Massarani et al., 2021). Journalism thus assumed a very important role – that of disseminating information to the masses. Massarani et al. (2021) argue that journalism played a very crucial role in providing reliable information about the pandemic. In the same vein, Capurro (2021) maintains that news media are important and dominant sources of health information. Media reports enable people to learn about novel health threats (Capurro, 2021; Ouchene et al., 2024). It is for these reasons that the COVID-19 narrative dominated the public sphere; it became a priority for the media.

The prominence that was given to the coverage of the COVID-19 pandemic reignited discussions about the role of science and health journalism, especially during a crisis. COST (2021) notes that COVID-19 placed science at the centre of the public debate. There was an urgent need to ‘tell meaningful stories about scientific topics that would have an impact on citizens’ (COST, 2021), and thus create a ‘strong demand for science journalism’ (UNESCO, 2021). Science and health journalism plays a significant role in communicating about scientific knowledge and public health information to the public (Chuarasia et al., 2020). It is through science and health reporting that the public receives scientific, evidence-based information about disease and viruses, consequently shaping their views about diseases, their treatment and prevention (Chuarasia et al., 2020; Cheung et al., 2023).

While the recognition of the role of science and health reporters in the value chain of social and behavioural change communication continues to gain momentum, it is important to note that science and health journalists require specific capacities and capabilities to repurpose and contextualise messaging to reach different audiences. In addition to these capabilities, the actual place of science and health journalists in the health communication continuum continues to be mostly misunderstood and overlooked. This poses challenges for them in accessing the appropriate skills and capacity-building opportunities. In this chapter, we explore the systemic and capacity challenges of science and health reporters in South Africa and Namibia. Specifically, the chapter explores the experiences of science and health journalists who reported on COVID-19 in South Africa and Namibia, the challenges encountered by these journalists in reporting about COVID-19 and the capacity needs for effective reporting on science issues. The chapter argues that understanding the capacity and capability needs of science and health journalists will contribute towards skills enhancement and more effective science and health journalism.

### **The role of science and health journalism during the COVID-19 pandemic**

Science journalism can be described as journalists' attempts to obtain and present scientific information in a simplified manner (Shehab, 2020), while health journalism is concerned with the dissemination of medical and health information (Paul et al., 2021). In other words, science and health journalism aims to simplify complex information in ways that the general public can understand (Shehab, 2020). Thus, it will involve translating health information into plain language and enabling the adoption of protective measures (WHO, 2021). Science journalism presents scientific information in ways that boosts people's ability to think critically and independently about issues presented to them (WHO, 2021). Based on these definitions, it is evident that journalism and the media played an important role during a health crisis such as COVID-19 – one of preserving public interest and public health (UNESCO, 2021).

Christians et al. (2010) discuss the normative roles of journalism. Normative roles explain the expected roles that journalists must fulfil in order to make a contribution towards society. Hanitzsch (2017) believes that the roles of journalists are socially negotiated, sensitive to context and place emphasis on journalism's contribution to the effective functioning of society. While it is recognised that journalism's roles are socially negotiated and in a state of flux, the field does have generally accepted roles. According to Christians et al. (2009), journalists can assume four roles: monitorial, facilitative, radical and collaborative. Christians et al. (2010) also note that journalists play a facilitative, enriching and disseminator role during a health crisis. By assuming these roles, journalists are in a position to understand audience needs, serve these needs and then monitor and observe the environment for trends and threats (Christians et al., 2010).

Under the monitorial role, journalists assume the overseer or surveillance role (Christians et al., 2009). Here journalists and the media bring to the attention of society issues that are of concern to them, especially if these are issues that threaten society. During the pandemic, journalists in some cases fulfilled this role. For example, in South Africa (BBC, 2020) and Zimbabwe (Chigono, 2020), journalists reported on the misuse of funds which were allocated for COVID-19 emergencies. In this instance, the media played a monitorial role. In terms of the facilitative role, journalists reporting on COVID-19 assumed the informative and educative roles in order to provide timely and in-depth information on the pandemic (UNESCO, 2021). Society was informed to enable informed decision-making on health-related matters. The collaborative role of journalism saw journalists and the media working with government to provide timely information to the public about the pandemic. The media became the means through which the public could be reached with COVID-19 messages. Journalists were invited to press briefings on COVID-19 updates, and this was imperative for the media to serve society with necessary and relevant information. In Namibia, for example, a COVID-19 Communication Centre was developed to provide relevant information to the public through the media.

Presidential and ministerial updates were conducted regularly, and the media participated in these gatherings. In South Africa, presidential updates were also aired to the public via television and other channels of communication.

## Literature Review

### **The role of journalists providing health education during health crises: The Case of COVID-19**

Numerous studies have been conducted on journalism's role in providing health education to the public during the COVID-19 pandemic (see Arriaga, 2021; Perreault & Perreault, 2021; Houston, 2021). These studies confirm that 'journalism served as a conduit through which the public learnt and also shared their experiences about Covid-19' (Perreault & Perreault, 2021). Perreault and Perreault (2021) argue that journalism was part of the 'Covid-19 disaster communication ecology'. A communicative ecology basically defines resources for information during a crisis (Perreault & Perreault, 2021). In the case of COVID-19, the communicative ecology of the public would consist of information and communication resources that individuals needed to cope with this pandemic (Houston, 2021). Houston (2021) further explains that communication ecologies provide resources which can enable individuals to achieve a particular goal. For instance, in a time of crisis, people may use the communication ecology to seek and share information that can assist them in coping with the crisis. While they may have been many other sources of information on COVID-19, it is safe to argue that journalists were part of the COVID-19 disaster communicative ecology. They provided information that the public used to make informed health decisions.

In the sub-Saharan Africa context, media also played a crucial role during the height of the COVID-19 pandemic. The study conducted by Wollnik (2021) on the societal importance of journalistic health reporting on COVID-19 in sub-Saharan Africa observed how health reporting during crises provides a variety of normative functions of journalism in democracies.

Furthermore, Drabo (2021) concedes that journalists and the media were essential in keeping the public informed about the pandemic and the preventive measures. Chiumbu et al. (2022), Maractho and Omland (2022) and Dralega et al. (2022) conducted framing studies in South Africa and Namibia, Uganda, and Ghana, Sierra Leone, Ethiopia and Zimbabwe respectively, in order to understand how media in these different countries reported on COVID-19. At the centre of these studies is the appreciation that journalists and media play a significant role in ‘discourse setting by the way they frame and communicate crises.’ These studies further highlight the crucial role of journalistic health reporting in influencing how people make decisions regarding their health. While the role of science and health reporting is in no doubt, journalists often encounter challenges which hinder or limit their ability to fulfil their roles.

### **Challenges associated with science and health journalism during the COVID-19 pandemic**

Despite the recognised roles of journalism, Sujoko (2022) argues that the ability to provide information and educate people can be influenced by numerous factors. These factors can be internal (personal factors) to the journalists or external ones. Thus Perreault and Perreault (2021) argue that the ability of journalists to disseminate meaningful science and health information depends upon the capacity of journalists and the overall composition of the media environment. One of the issues that affected the ability of journalists in fulfilling their normative role was the overflow of information about COVID-19 on social media platforms. This overflow of information made it difficult for the public and even journalists to assess the veracity of claims made. The term ‘infodemic’, coined by the WHO (World Health Organization), describes the amount of information that was spread about COVID-19, especially on social media platforms. Sujoko (2022) contends that this problem with social media, especially when news is spread first by social media, is that journalists often missed or failed to update points related to the pandemic (see also Riedlinger & Montana-Nino, 2024)

Another challenge that confronts science journalism is the relationship between journalists and sources (see Marín-González et al 2023). Peters (2013) maintains that “the relationship between science and the media has been characterised by metaphors and terms such as ‘distance, gap, barrier, fence, oil and water and creative tension’”. This explains why journalists and sources often act like strangers to each other, often do not understand each other’s language and scientists often carry negative perceptions regarding journalists’ coverage of science matters (Peters, 2013). Another dimension of looking at challenges related to sources and science journalism is the overreliance or dependence on a small ‘influential’ pool of resources. Schafer (2011, cited in Massarani et al., 2021) highlights that from a vast amount of scientific information produced, science journalists generally draw on a small number of ‘influential’ sources. This may arguably mean that some narratives are favoured over others.

Access to information is another concern which science journalists encounter in their reporting on science matters. For instance, Perreault and Perreault (2021) have opined that pandemic pressures tend to be intensified by, amongst other factors, the pressures of not getting correct information that needs to be relayed to the public. This is because, in the case of COVID-19, health agencies were not releasing consistent messaging about the pandemic (Perreault & Perreault, 2021). It became an almost expected occurrence to hear about constant adjustments in the health messages about COVID-19, especially on how it could be transmitted. In some cases, there were constant adjustments on how the disease spread and this also led to many questions arising on the effectiveness of suggested methods of prevention. This meant that journalists were in many instances reporting on contradictory messages from government and scientists (Radcliffe, 2021). In some cases, journalists were barred from reporting on certain information relating to COVID-19. A case in point is when certain Namibian journalists were barred from covering the inauguration of a COVID-19 isolation facility (IPI, 2020).

The need for training science and health journalists has also been highlighted in the literature (see Jamil, 2022). This

empowers journalists with knowledge on how to tell scientific stories that can engage the audience. Fischhoff (2018) explains that communicating science effectively requires practitioners to know how to send or share the information that they have received. This places emphasis on the communicators' ability to select, process and package information in a manner that would be easily comprehended by the receiver (Mulchandani, et al, 2024). The ability to effectively communicate was undermined by journalists' limited understanding of the pandemic and its complex nature. Much of the reporting, using South African print media as an example, was characterised by Wasserman et al. (2021) and (Ndlovu & Nikabs, 2023) as alarmist, negative, episodic, superficial and lacking in-depth analysis. To further demonstrate limited understanding of the pandemic, Lukanda and Walulya (2021) looked at media coverage of COVID-19 in Uganda and Tanzania. They found that media focused on issues related to statistics (COVID-19 figures), prevention and issues related to the lockdowns (Lukanda & Walulya, 2021). This approach to reporting re-emphasises a lack of depth in reporting, as journalists focused, without critical analysis, on information provided by dominant sources. To provide further discussion on factors that could affect the ability of journalists to fulfil their normative role during a crisis, the next section will look at the hierarchy of influence model.

## Theory

### **The hierarchy of influence model**

The hierarchical model of influence was developed by Shoemaker and Reese (1996) with the intention of trying to understand influences on media content. Earlier efforts directed towards understanding media content, specifically factors that shaped media content, can be attributed to the works of Gans (1979) and Gitlin (1980), who were of the view that media content is affected by factors like media workers' socialisation and attitudes, media organisation policies and routines, and social institutions, and they argued that media content was a function of ideological positions. It is from Gitlin (1980) that Shoemaker and Reese

(1996) were able to develop a more comprehensive framework to understand influences on media content (Reese, 2019), which they termed the hierarchical model of influence.

According to Shoemaker and Reese (1996), the model uses five levels of analysis to understand influences on media content. The levels of analysis include the individual level, routine level, media organisation level, social institutions level and social systems level (Shoemaker & Reese, 2014, 1996). At the individual level, the model assumes that the characteristics of individual communicators matter in the process of content creation (Reese, 2019; Shoemaker and Reese, 1996, 2014). For Gans (1979) and Gitlin (1980), this level is a communicator-centred level and focus is placed on factors that can hinder individual work. The next level of the model is the routine level. This level focuses on how media work is organised and how routines within media organisation could have a constraining effect on journalists. Reese (2019) believes that newsroom routines or the immediate environment of the work of journalists can influence content creation. The organisation level explains how news is produced within entities or organisations that have set policies and economic imperatives (Reese, 2019). Hanitzsch et al. (2010, cited in Jamil & Appiah-Adjei, 2020) comment that organisational policies and their role in addressing commercial goals can have an influence on media content. The last two levels, social institution and social systems level, acknowledge the influence of factors outside the media organisation (Jamil & Appiah-Adjei, 2020). The social institution, according to Reese (2019), considers the influence of advertisers, social institutions and technology on media content, while the social systems level pays attention to how ideological forces may shape the work of journalists (Reese, 2019).

While this model offers some explanation of the diverse streams of influence which potentially impact on news content, some criticisms have been levelled against it. For instance, some critics argue that the theory does not provide clear boundaries between the different levels of influence (Anderson et al., 2012 in Jamil & Appiah-Adjei, 2020). Despite this limitation, Jamil and Appiah-Adjei (2020) believe that this model is still relevant as it can help in understanding systematic irregularities that can

influence media content. In this study, this model is useful in helping to understand the coverage of COVID-19 and unpack the systemic challenges that affected COVID-19 reporting amongst science and health journalists.

The ability of science and health journalists to provide quality coverage of science news is influenced by numerous factors. This notion is supported by Reese (2019), who contends that the creation of news content happens within a larger institutional and ideological context. This institutional and ideological context provides different sources of influence, and Shoemaker and Reese (1996, 2014) have proposed the hierarchy of influence model in order to understand these influences.

## **Data collection**

In order to explore the systemic and capacity challenges of science and health reporters in South Africa and Namibia, more specifically the experiences of science journalists and journalists who reported on COVID-19, the challenges encountered by these journalists in reporting about COVID-19 and the capacity needs for effective reporting on science issues, a qualitative research approach was adopted. This was done in order to provide an in-depth understanding of the participant's views on the subject under investigation. As a form of qualitative inquiry, interviews were used to document participant's experiences, challenges and capacity needs when reporting on a health crisis.

Given the prevailing COVID-19 circumstances and established health protocols (at the time of conducting this study), telephonic and Zoom interviews were conducted. An interview schedule was developed to allow the research to focus on issues pertinent to the study while at the same time allowing for issues to be explored as they emerged from the discussions (see Ryan et al., 2009). Participants were purposively selected journalists who had reported about COVID-19 in South African and Namibian newspapers and science journals. A total of 17 journalists from South Africa and Namibia, eight and nine participants respectively, were selected.

The process of data collection was preceded by an application for ethical clearance at Namibia University of Science and Technology and the University of Johannesburg and was granted. Informed consent (see Nnebue, 2010) was sought and obtained from participants. In Namibia, a researcher was appointed to interact with participants. This involved setting up schedules for the interviews and conducting the interviews. Questions posed to the participants centred on, amongst other issues, experiences, challenges and capacity needs when reporting on a health crisis such as COVID-19. Some of the questions emerged from the responses provided by the participants. A similar data collection process was followed by the researcher, who collected data amongst selected South African journalists. The interviews were recorded on the Zoom platform and also using a voice recorder. Recording was essential to correctly capture the views of the participants. An identification code was developed in order to protect the identity of the participants (see Saunders et al., 2015). The codes NA01 to NA09 (Namibia) and S01 to S08 (South Africa) were used to identify participants.

## **Data analysis**

Deductive thematic analysis was employed to analyse and attach meaning to journalists' views on their experiences, challenges encountered in reporting about COVID-19 and the capacity needs for effective reporting on science issues. The process of data analysis involved the transcription of interviews from an audio format to a written transcript. Before coding began, transcripts were read several times in order to understand the content. Open / initial, axial and selective / theoretical coding (see Saldana, 2009:81-167) was used. Open coding allowed for the close examination of participant views and to identify key words and phrases that describe their experiences. The key words and phrases were given descriptive labels and then organised into categories through axial coding (Saldana, 2009). Through the use of selective coding, themes with greatest explanatory relevance (Saldana, 2009:163) were identified and these are discussed in the next section.

## Results of the study

### Experiences of science reporters with reporting on COVID-19

The narratives below reflect the experience of science and health journalists who reported about the COVID-19 pandemic in South Africa and Namibia. Firstly, the pandemic is described as a complex issue which affected not only health aspects but various dimensions of society. NA08 commented:

It's a bit of a complex and multifaceted question because there is Covid-19, the disease itself, and then there's everything else around it, like the finance side. Your report will not really just focus on the disease itself; sometimes you're focused on maybe the money that's been spent by the government into Covid-19 ... Sometimes you're focusing on the laws that deal with Covid-19 ... (NA08, Namibia)

NA08 reveals the complex nature of the pandemic and how it challenged how journalists reported about the pandemic. This view is buttressed by Radcliffe (2021), who described the all-encompassing nature of COVID-19 and its effect on the practice of journalism. According to Radcliffe (2021), the constantly changing nature of COVID-19 placed specific demands on journalists. Because of these demands, reporting about COVID-19 was not an easy assignment for some journalists. To highlight this, some of the participants commented:

I think when it comes to covering Covid-19 stories, it hasn't been a walk in the park. Health is a very sensitive matter; you can't just jump onto it and start covering it. But I gained a lot ... it's a year of experience covering Covid-19 related stories. (NA03, Namibia)

Well, in general, I think we have all just learned along the way, we have learned to ask certain questions. When you go back to the office, and you start writing your story, you realise there is this gap, you need to get clarity on this thing. And from the beginning, there was no guidebook. (NA05, Namibia)

## Chapter 4

You will never talk confidently about something new and Covid-19 was new when it came ... and our way of reporting will tend to be based on that information that we get from the government and relevant partners. (NA07, Namibia)

... the whole Covid-19 thing was a learning curve, and it caught everybody else by surprise. ... so most of the things about Covid-19, we actually learned as we go even up to this day. You can't convincingly tell anyone that you know everything there is to know about Covid-19. (NA06, Namibia)

While reporting on COVID-19 was a 'learning curve' for some journalists, a number of South African journalists had a science background, which influenced how they reported on COVID-19.

I think because I have a science background it made it very much easier for me to talk about all the new concepts that were coming through for Covid-19 ... (S02, South Africa)

Well, I am a very lucky person because at the very beginning I am a vice president of the world federations of science journalists and in the very early days of this pandemic, we decided that we are going to collate science, corporate science for journalists. I was gathering the preprints, the latest peer-reviewed published sources, so I was getting information that was informing my reporting on Covid from really just about every outlet ... (S07, South Africa)

Similarly, some participants describe how their background played a role in how they reported COVID-19 issues. S06 expressed the following:

I think firstly it is important to say that I had a very interesting and . . . unique experience during the pandemic, especially at the start of the pandemic, because while I am a reporter, while I am a journalist I am also an intermediate paramedic, and ... I think my experiences as a healthcare worker helped shape my reporting. I was doing work as a

freelancer and I did stories for Aljazeera, I did stories for Health eNews... (South Africa).

SO8 also believes that background knowledge informed how well they reported about COVID-19:

Well, I think my biggest advantage is that I have been able to log onto the webinars that have been sponsored by Discovery Health. So I have used this material for education and I have been able to convert this information shared by professional people, doctors etc. (SO8, South Africa)

Despite NA01 not having background knowledge in science and health reporting, the views of this participant confirmed the role of experience and background towards effective reporting:

Your level of knowledge about a certain topic would actually also guide you in terms of how to write a certain topic, like Covid-19, for instance. A lot of us still don't know everything. Of course journalists read more and know more. But it's still very complex . . . Covid I understand it mutates ... (NA01, South Africa)

The experiences by some journalists while reporting on COVID-19 have been attributed to changes in the newsroom, which have necessitated the use of general assignment reporters instead of specialised reporters. Participant S07 commented:

Well, I am going to make a distinction here: there are science journalists in this country, there are health journalists in this country and there are generalist journalists in this country and sadly what has happened to the media in the last 10 to 20 years has impacted on how we have reported on Covid. It's very few and far between that you will find the media that have budget to employ a science or health journalist, so what happened at the beginning of this was they slimmed down, they kept newsrooms, you know, with a few generalist journalists in it often fairly young ... A lot of people were [swimming] in the deep end and didn't . . .

have some basic skills that you learn, as a science journalist or the health journalist ...(South Africa).

The narratives above reflect participants experience while reporting on COVID-19. It is evident that background knowledge can influence how journalists report about science matters. It is also evident that organisational factors can impact on quality science and health reporting.

### **Personal initiative and its contribution to effective COVID-19 reporting**

The study also observed that journalists who took on the responsibility of reporting about science or COVID-19-related matters without the necessary skills or knowledge used their personal initiative to ensure effective reporting. NA01 explained:

I read on it a lot to just keep myself informed and to write informed pieces and to ensure that I'm writing factual stories, based on what I'm hearing from the experts, or also just if the government gives me a response ... (NA01, Namibia)

NA04 emphasised the role of research in reporting about COVID-19:

I think obviously, because of research, and also checking whatever was happening everywhere in the world, and also engaging with various sources, within a very short period of time, it pretty much put me into a position where I think I understood faster, and ... didn't take that long to grasp the concept.

Similarly, NA05 explained how they participated in workshops to improve on their reporting.

From the beginning, there was no guidebook. We have learned along the way, but I have also reached out and I have taken part in a number of trainings, online trainings, I have done one with Bhekisisa, which is part

of the *Mail & Guardian* ... the medical section, I have done trainings on vaccinations, I have done some on Covid and reporting (Namibia).

Perreault and Perreault (2021) have argued that, in reporting about COVID-19, journalists encountered a lot of difficulty but were able to find ways of dealing with forces “pressuring their work”. This view is shared by Radcliffe (2021), who contends that challenges associated with reporting on COVID-19 “compelled journalists to learn new skills related to health reporting”. These observations are in line with the findings of this study, which highlight that journalists had to use their personal initiative in order to ensure effective reporting. The next section discusses the challenges encountered while reporting on COVID-19.

## **Challenges encountered while reporting on COVID-19**

Journalists encountered various challenges while reporting on COVID-19. Some of the challenges relate to the inconsistencies in messages or information about COVID-19 and also relationships with sources.

... but the problem was just like in the USA, the doctors and specialists were saying a different message from the government. So it was very, very confusing ... (S04, South Africa)

So we would speak to the minister, and he was always accessible but you could not rely on the information he gives you. Because it's as if his team within the ministry did not properly inform him. When you ask him a question . . . sometimes it will be . . . something that you can't work with, or it's something that is unimportant. Then you speak, let's say, to the CDC, and then they will [contradict] the information. He says one thing, the CDC says one thing, and then you're like, Okay, what is it? (NA01, Namibia)

To support the views above, research has shown that journalists have, in some instances, reported contradictory guidance received

from public health officials (Radcliffe, 2021). Related to the nature of information received, are the views of journalists regarding sources of information. While accessing sources appeared not to be a challenge, journalists were concerned about the sources they engaged with. For example, S01 explained:

Yes, sometimes you find that experts are going to weigh in ... because I don't know if they want the media moment or they make themselves very available and their expertise isn't exactly . . . it's not like public health or immunology or specifically related and I found often we get sources that aren't, I don't think connected enough to the science they're speaking about .... you need to make sure that you're speaking to an expert who is deeply involved in those kind of questions rather than maybe a public health expert who can speak generally about it (South Africa).

This was a concern because for S01 the kind of information a journalist receives from a source will impact on the way in which a story is framed. Another participant also highlighted a similar challenge with sources:

So the Ministry of Health, the CDC, some nurses in the industry, some private doctors were not very helpful. So I have really also picked up that not all of them are on the right track. (NA05, Namibia)

Participants' concerns about sources place emphasis on the importance of accessing reliable and credible information sources (Radcliffe, 2021), especially during a pandemic. In addition to the findings above, it emerged from the findings that journalists had concerns about the ability of scientists to communicate about the pandemic. According to S06, scientists lacked the ability to transfer knowledge to the public. A participant commented as follows:

... it's not just to support journalists in getting the knowledge but it is also to train our scientists in communication, because we have a lot of phenomenal

scientists and researchers in this country who very often lack the ability to transfer that knowledge to the public and if that knowledge doesn't reach the streets then it isn't worth that much. (S06, South Africa)

This observation is supported by MacArthur et al. (2020: 62), who believe that scientists “need help to engage and communicate effectively ... they must be prepared to interact with different publics and share scientific information clearly and efficiently”. In addition, Auerbach et al. (2020) stress the importance of better preparing scientists for effective communication.

### **Capacity-building needs for effective science and health reporting**

Participants were asked to reflect upon the capacity building needs for effective science and health reporting. It emerged from the findings that there is a need for journalists to develop critical thinking skills, benefit from mentorship, training and education, and develop the ability to communicate about science in a simplified way as well understanding how to nurture relations with scientists or sources of information.

### **Development of critical thinking skills**

Critical thinking, number 1, if I read, if you read something on the article don't take it as it is, you know, your job is to go deeper into that, and that is like interview skills, how do I ask questions that give real answers ... (S01, South Africa)

Critical thinking emerged as one of the important skills required for effective science and health reporting. It is a skill that compels journalists to question the information they receive before they share it with the public. It requires journalists to verify and understand information presented to them. S03 commented:

... if you look at one of Harvard's articles you really have to concentrate if you want to get what they want to say ... [journalists] must have the ability to read that, understand

it and [express] it in plain English so that people understand ... they [must] also have the ability to think laterally and tackle topics around Covid ... (S03, South Africa)

S07 expressed the following:

I was talking about how to read, interrogate and use science ... those are key skills ...(South Africa).

Critical thinking is considered by participating journalists as one of the important capacity needs of science and health journalists. This view is supported by existing literature, which also emphasises that critical thinking can help journalists to “raise vital questions and problems by coming in grips with a topic; gather and assess relevant information; think open minded (challenging any assumptions) and enable journalists to communicate effectively with others”

### **The need for mentorship towards effective science reporting**

Mentorship was also identified as another key essential element needed for effective science journalism. Support from editors and senior journalists and empowering journalists was seen as key:

... and with the capacity ... the editors should be giving the support and encouragement, I mean if there were more mentors for this field ... if mentorship was maybe more robust. (S01, South Africa)

NA02 shared a similar sentiment:

So more mentorship and understanding of senior journalists ... guidance and also more on sources ... It's difficult to build these relationships with medical practitioners. (NA02, South Africa)

Another participant highlighted the need for empowerment:

Okay, the first issue is to empower journalists, give them options, if I want to venture into health reporting, for example, empower me enough in the newsroom, let there be that person who assists me to identify the sources, access the sources, get the information, analyse the information, be able to present the information in the most simple way that can be understood by everybody, and also sometimes get an opportunity to go to these workshops ... go to also international workshops, where you engage with other people in this beat, learn what needs to be done. (NA04, Namibia)

Participant NA04 further explained the need for senior staff to offer support for health journalism:

My opinion on this issue is, it comes down to the senior or the backroom staff in most of the newsrooms in Namibia. Health reporting is not incentivised – well, nobody really cares whether there is a health reporter or there's no health reporter in the newsroom ... So I think incentivising the beat itself has been the biggest problem, getting support from the backroom staff for this beat has been a big problem (Namibia).

El-Awady and Lublinski (2007) believe that mentorship by senior journalists is important in improving the quality of science reporting and maintaining professionalism. In line with the views of the participants, El-Awady and Lublinski (2007) go on to argue that mentorship can help science journalists know how to identify sources and good stories and it is a means of improving the skills of science journalists.

### **The role of training and education for effective science reporting**

Related to mentorship is the need for training and education focusing on science and health journalism. The lack of training

workshops and the limitations of formal journalism education in universities were highlighted by the participants. Some of the participants opined:

I think we are not skilled like we are supposed to be. ... [at] all the universities in South Africa one is never trained to be a health journalist and one is never trained to be science journalist; it's something which we have to learn after we have graduated ... (S04, South Africa)

So we definitely need more training on specific issues. Like I have said, I've had the privilege to attend a training on vaccinations and what I should know about vaccinations, and number of questions that we need to ask, I could ask there, definitely how Covid works, how a pandemic works, how a virus works, because very often people don't understand that a virus mutates. Journalists need to be trained about that, they need to understand the nitty gritty of working with diseases and viruses. (NA05)

I think it's important to have a variety of training sources and a variety of resources for people to tap into because that helps us as journalists ask the right questions specifically over public officials and specifically of the people who are running the pandemic response because if we allow them to train us then we are going to be thinking in the way that they want us to think. (S06, South Africa)

To emphasise the need for training and education, some participants highlighted the lack of training:

It [training] really lacks. We don't have a lot of trained people like I told you, not just health reporting but any other kind of reporting. I think a lot of journalists need training, especially if you want to be a health reporter or a scientific reporter. It's a very complex topic it would be nice to be actually trained earlier on. ... Journalists really need extensive training; capacity is really lacking. (NA01, Namibia)

So capacity in terms of science stories, we don't understand what the situation is, what the scientific processes are, what the health issues are. There is a major lack in capacity when we speak about knowledge and understanding of these things and because of that you saw in the first few months it was a lot of different media information coming from different media houses. (NA02, Namibia)

The narratives above speak to the need for training, through workshops and even at tertiary institutions, to capacitate science and health journalists. Menezes (2018:3) agrees that training science journalists is imperative, as it will enable them to 'become more discerning translators of scientific information'. Menezes (2018) also argues that training will enable science reporters to understand scientific methods and place them in a position where they are able to write stories that have a broader context and are relevant to their audiences. Training is therefore seen as a mechanism that would address the barriers faced by journalists when reporting on science matters.

### **Use of appropriate language in science and health reporting**

Participants also highlighted the need for journalists to be able to use appropriate language when communicating about science issues.

The other thing that I was saying was the art of communicating science, these

storytelling elements to it, the people miss out, they just report and ... you have to tell a story in some way, you have to go to humanness of people and grab that and when you give them scientific underpinnings, you know, it is in a way that is digestible. So that's something that you know you can learn, by looking at really good science communication, by going to webinars and training sessions. (S07, South Africa)

You need to set up how you will get the information to the people in the way they will understand .... access to the [grandmother] in that village . . . and not just live on TV, but radio because they would have the information and speak the language that they understand. It should not just be in English, because you can't use words that they can't understand. It should be worded in a manner that they can get and that they can then explain to the next aunt in the same village. (NA09, Namibia)

Another participant explained:

It will be maybe figuring out the different strategies of what your key message is; understanding how to get it down. Let's say you want to talk about cancer: what is your objective about cancer? Figuring what the key messaging is and how to communicate the key message will be quite important. (NA02, Namibia)

According to Radcliffe (2021), it is important for journalists to understand how facts and figures can be translated into stories that can impact on society. Suharno and Sastra (2001) explain that using complicated language in science reports does not help; instead, it misleads or confuses readers. This places emphasis on the need to train science journalists on how to use appropriate language when communicating scientific information.

### **Developing relationships with sources**

It emerged from the findings that science journalists need to be equipped in terms of how to build and nurture relationships, particularly with sources.

I think relationship building is the centre, because . . . when it comes to doctors, health practitioners, time is spent in nurturing those resources, trusting that the media is not there to frame you in such a bad light. I think that is why those professionals are scared because they think that that the media is out to get them. So trust, building

relationships with these medical institutions and giving us the mentorship and the information we need ... (NA02, Namibia)

You have relationship building and networking that will be the most pressing because we don't have relationships. We can't talk to each other the way we talk to politicians. The relationships aren't there. So relationship and networking will be one of them. (NA02, Namibia)

For other participants, the ability to ask the right questions is an important element in building relationships with sources. Participants shared the following comments:

Yah, the skills of asking the right questions to the right individuals so that he or she will be able to give the (right answer), having the right answers to his readers and then he will also know how to communicate with people ... I think the manner of approach, the communication skills is the other skill ... (S05, South Africa)

I am not the expert and what I need is a network of people who are available that I can pick up the phone and [say]: . . . you said this, what does it mean in normal language? So I think that having a network is very important and I think knowing how to ask the right questions is important. (S06, South Africa)

In line with the narratives above, Hertzum (2022) stresses the importance of building relations with sources. He contends that there is a “need for building rather than presuming rapport” (Hertzum, 2022) in the source–journalist relationship. This is crucial since the journalist and scientist relationship is usually characterised by prejudice (Hertzum, 2022).

## **Discussion of findings**

It is evident, from the findings above, that science and health reporting is influenced by various factors. Sujoko (2022) and Perreault and Perreault (2021) all agree that the ability of

journalists to tell meaningful science stories depends upon the capacity of journalists as well as factors external to the media organisations. This view is supported by the findings reported in this chapter, which have highlighted the influence of different factors on how journalists reported on COVID-19. What is clear from the findings is that the individual characteristics of journalists played a role in how they reported about COVID-19. In this case, some journalists did not have background knowledge on science reporting while other reporters had some experience with reporting on science and health issues. Reese (2019) has argued that the characteristics of individual communicators matter in the process of content creation. This view is useful in helping to explain why for some journalists reporting on COVID-19 was 'not a walk in the park' while for some they were becoming 'naturals' at reporting on COVID-19 every day. While individual characteristics matter, it is also evident that there is an interplay of factors.

The lack of specialised reporting in news organisation due to economic interests and less focus on science matters can also be seen as a factor in journalists' inability to effectively report on science and health stories. Hanitzsch et al. (2010) referred to the influence of organisational policies on news content. They argued that organisational policies and their implementation, particularly to address economic interests, tend to impact on media content (Hanitzsch et al., 2010, cited in Jamil & Appiah-Adjei, 2020). Because of budgetary issues, some news organisations assigned general reporters or reporters specialising in other beats to report on COVID-19, and this could have contributed to some of the weaknesses observed in COVID-19 reporting.

The findings have also highlighted how science reporting was informed by the information received from sources. The framing of stories depended on the information journalists obtained. To explain this, Reese (2019) discusses the social institution and social systems level of the hierarchy of influence model. Social institutions can determine the dominant narrative to be communicated with the masses through the information they share with science reporters. Therefore, what dominated the public sphere in the case of COVID-19 reporting is largely what

emerged from sources of information, which in many instances was the government. The findings also highlighted challenges with inconsistent messages, sources of information and the ability of scientists to effectively communicate. Perreault and Perreault (2021) argue that journalists' reporting on COVID-19 was undermined by the pressures of not getting correct information. This is confirmed by participants' narratives which show how they received different information on the same issue from different sources, thus reporting contradictory messages in some instances. Fjaestad (2007) highlights that the media has often criticised sources or scientists for expressing contradictory opinions on important matters and in some instances for withholding and repressing information that needs to be shared with the public.

The findings also highlight how in some instances journalists questioned the credibility of sources of science information as well the ability of scientists to communicate in ways that will allow journalists to relay this information to the public. Anderson (2017) explains that the relationship between science journalists and scientists has a long tradition and is an important factor influencing journalists' decisions within the production of news. However, this relationship, as Peters (2013) argued, has always been characterised by tension. Often journalists and scientists do not understand each other's language and in some cases have negative perceptions towards each other (Peters, 2013). Thus de Semir (2000) has argued that the interaction between science and media is inevitable and calls for a new relationship to be forged in order to support effective science reporting.

The need for training and education is another important finding from this study. It is through training and education that science journalists can be equipped with the ability to develop and nurture relationships with sources of information, acquire skills to frame and package science stories in a language that is easily understood by the public and develop critical thinking skills to interrogate information they receive beyond what it simply says. Smith et al. (2017) have argued that training gives journalists confidence and skills for science reporting. In the same vein,

Fischhoff (2018) explains how training can help practitioners know how to process and share information they have received. De Semir (2000) also emphasises that the reporter must be a 'translator' who is able to convert information from a specialised source into something that can be understood by a more general audience with no background knowledge of the information (Sobane et al., 2023). This is possible if science journalists are empowered with the requisite reporting skills. Furthermore, de Semir (2000:128) explains that the challenges often associated with science reporting, such as "sensational news, a lack of analysis and perspective when handling scientific issues, excessive reliance of certain sources, lack of criticism of sources, lack of criteria for evaluating information", can be attributed to a lack of training and education. These views are consistent with participants' views on the role of training and education in effective science reporting.

## Conclusion

Findings of this study confirm that science journalism has an important role to play, especially in a health crisis where information plays a central role. To fulfil this role, there is a need to acknowledge the existence of factors that limit the capacity and capabilities of science journalists. These limitations manifest at different levels, for instance at individual, organisational and social level (Reese, 2019) and tend to influence how journalists report on science matters. The study further argues that there is a need to empower science journalists with requisite skills for effective reporting. The role of education institutions and training in general has been highlighted as an essential element towards capacitating science journalists. Education and training will enable science reports to be critical in their approach and develop knowledge on framing and packaging of scientific stories in ways that will matter to the public. Training will also provide strategies on how reporters can develop and nurture good working relations with relevant sources. In a nutshell, this chapter is arguing that understanding of journalist's experiences with reporting on science matters is an important starting point towards

transforming and empowering science and health reporters so that they are able to fulfil their normative roles in society.

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## Chapter 5

# Towards a Health-Promoting Campus: Institutional Complexities in Communicating Health Information in Uganda's Higher Education Sector

Aisha Sembatya Nakiwala 

### Abstract

Communication to promote health behaviour in diverse settings has increasingly become essential due to the growing number of global health crises. Education institutions, as settings, appear to be unlikely locations for promoting health, despite that education goals are intrinsically enabled through good health. In fact, universities are now considered an important setting for health and its promotion to advance both education and health goals. However, actual practice is rare in sub-Saharan African countries, where health-promoting universities have been slow to emerge and to adopt significant health promotion values. A qualitative study involving primary and secondary sources of data was conducted, which revealed several barriers that constrain the implementation of health education and promotion within university settings in Uganda. These challenges were mostly institutional and require a shift in policies and practice for the education sector to fully embrace health promotion in university functions, routines and processes.

## Introduction

Despite belonging to a sector that seems like an unlikely location for promoting health, many universities all over the developed world implement health communication strategies to foster healthy campuses and to encourage students, staff, and communities to adopt healthy behaviours (see for example Hatfield et al., 2024; Wordlaw & Vilme, 2024; Wang et al., 2023). However, such initiatives are uncommon in sub-Saharan countries where health-promoting universities have been slow to emerge and to adopt significant health promotion values.

This chapter explores the challenges facing health initiatives and the communication of health information in Ugandan universities. The emphasis is on Makerere University in Kampala, although reference is also made to other public universities in the country. Makerere is Uganda's oldest university and is also its premier education institution. It has about 40,000 students, the majority of whom are undergraduates, together with a corresponding number of staff and visitors, all of whom spend a significant amount of time at the University. This makes this university a viable setting for promoting health amongst this elite and important group of people. In order to comprehend the implementation of university health programmes, the chapter presents an overview of the state of health status in universities in Uganda. The use of health communication in addressing health crises in universities is also discussed. The chapter concludes with a discussion of five complexities to communicating health in these universities which include: competing communication contexts; diverse health and epidemiological issues; lack of clarity of vision for health; inadequate funding; and misinformation and fake health news.

**Keywords:** health communication in universities; Uganda; misinformation and fake news; biomedical and behavioural paradigms

## Background

### **Health in institutions of learning: Uganda in context**

Understanding the complexities of implementing health communication in Ugandan universities requires an awareness of the health context in which universities operate. Given the scale of global health crises, the resulting impact for institutions such as universities and for the public in general has been far-reaching. The section highlights various health issues affecting students and workers in Ugandan universities, which include mental health, sexual and reproductive health, HIV (human immunodeficiency virus) and AIDS (acquired immunodeficiency syndrome), substance and alcohol abuse, and the recent Coronavirus disease 2019 (COVID-19) pandemic. The discussion does not provide an exhaustive review, but instead gives a broad representation of the health challenges confronting universities in Uganda.

#### *Mental health problems in Ugandan universities*

Mental health is a major issue in Uganda: 14 million Ugandans suffer from mental illness (*New Vision*, 2022). Higher education institutions are both significant victims and purveyors of mental illness, with university students being a significant social group afflicted by mental disorders (Amanya et al., 2018; Kaggwa et al., 2022; Muwanguzi, et al., 2023; Olum et al., 2020). For instance, a 2017 cross-sectional survey of Makerere University's health professional students revealed a 57.4% prevalence of stress, with academic and psychological stressors being the primary causes (Amanya et al., 2018). In a previous survey, first-year students at the same university had a depression rate of 16.2%. (Ovuga et al., 2006). According to Ovuga et al. (2006), the challenges of living in a post-conflict nation, poverty and diseases like HIV/AIDS exacerbate the problem. Drug and alcohol abuse by young people at Ugandan universities worsen the symptoms of mental illness (Kamulegeya et al., 2020; Okahaabwa et al., 2020). The COVID-19 pandemic also played a significant role in exacerbating mental health issues amongst Ugandan university students (Najjuka et al., 2021). Thus, interventions to address the individual and social drivers

of mental health are necessary to deal with the mental health challenges at these institutions. In terms of communication, the Makerere University Department of Mental Health in the School of Psychology organises regular peer-to-peer education campaigns in students' residential halls to promote mental health awareness amongst students. These initiatives typically include interactive sessions where the targeted students can ask questions as well as attend presentations by students studying mental health.

### *Sexual and reproductive health amongst university students*

University students around the world are susceptible to sexually transmitted diseases because they comprise a sexually active group. According to research, many Ugandans begin having sexual relations by the time they turn 18 years old (MoH & ICF, 2012). As they start having sexual relations, young people are also said to participate in risky sexual behaviours such as unprotected sex, transactional sex, coercive sex and having multiple sexual partners (Choudhry et al., 2014; Darabi et al., 2008; Kaaya et al., 2002). According to a survey of university students in Uganda, 60.3% engaged in sexual activity, resulting in unwanted pregnancies and maternal and neonatal health outcomes which are now frequent amongst Ugandan youth (Mehra et al., 2012). Another survey revealed a high prevalence of sexually transmitted infections (STIs) amongst students (Aluzimbi et al., 2013).

### *HIV and AIDS epidemic in Uganda*

The HIV/AIDS epidemic continues to impact Uganda, particularly young adult boys and girls, and it remains a threat to the education sector, including universities (Choudhry et al., 2014; Aluzimbi et al., 2013). Although Uganda reported a considerable decline in adult infections to as low as 6% in the middle of the 2000s (see Agardh et al., 2010; MoH & ICF, 2012), HIV/AIDS still contributes to poor health or death amongst students and staff, leading to a decline in academic output and enrolment (UAC, 2018). Given the sensitivity surrounding this disease, there is a lack of precise statistics on the prevalence of HIV/AIDS in Ugandan universities due to the absence of data systems and

attention paid to these subgroups in national data sources like the National AIDS Indicator Surveys (MoH & ICF, 2012). Nonetheless, anecdotal information suggests that the illness is rampant in universities. For instance, the Uganda AIDS Indicator Study (MoH & ICF, 2012:104) estimates that 2.1% of boys and 4.9% of young girls in Uganda between the ages of 15 and 24, including those at universities, are infected. In general, HIV/AIDS has a negative impact on the quality of teaching and learning at universities as well as the management of other academic and administrative tasks due to absences caused by illness or caring for the unwell. The methods used to communicate about reproductive health and HIV/AIDS in university settings in Uganda normally involve education drives through campuses to spread information to encourage students to use particular HIV/AIDS services like voluntary testing and male circumcision. Students also receive health information packages during their first year orientation and when they visit the university hospital during the course of their study.

#### *Substance and alcohol abuse amongst university students*

Young people in Uganda – a country that has the greatest alcohol consumption per capita in Africa (WHO, 2011) – use alcohol in the same way as the entire population does (Choudhry et al., 2014; Naamara & Muhwezi, 2014). Uganda's university students have a high prevalence of risky alcohol use, with 55.6% of those surveyed at Makerere University being heavy drinkers (Emyedu et al., 2017). This study also indicates that male students consume more alcohol than their female counterparts. Substance abuse is also common, with marijuana, shisha, cannabis, cigarettes, cocaine and opioids being frequently abused (Kamulegeya et al., 2020; Swahn et al. 2011). Alcohol and substance misuse can negatively affect academic performance and lead to brain damage and school dropouts. Factors that contribute to alcohol consumption and addiction amongst students include peer pressure, freedom, liberty, fewer restrictions and having a source of income to purchase alcohol (Kamulegeya et al., 2020). Interventions involving students, parents and institutional policies are necessary to address the problem. At Makerere, the university

counselling services websites normally contain information on various psychological stressors, including alcohol and substance abuse, which students are expected to access from time to time. Additionally, the counselling department provides information to students through workshops, public lectures and presentations.

### *COVID-19 and its impact on education in Uganda*

The COVID-19 pandemic highlighted the importance of applying the settings approach to health in Africa and around the world. In Uganda, the pandemic had severe impact on education, emphasising the need for policies and effective crisis communication to guide emergency responses to disease outbreaks. Ugandan education institutions suffered two closures and took two years – the longest time worldwide – to fully reopen. As a result, students suffered depression, mental health issues, and harmful psychological impact due to the fear and isolation that followed the outbreak (Najjuka et al., 2021). Moreover, while some universities, like Makerere, quickly embraced blended learning to fulfil its teaching obligations during the pandemic, stakeholder demands eventually compelled education institutions to fully reopen, despite obvious concerns about their ability to handle an expected rise in infections. The methods used to communicate COVID-19 information included the university health services websites and student emails.

This section has highlighted the critical health issues facing Ugandan universities and the urgent need for action to address them to ensure a healthier student and staff population in a constantly changing health environment. It is suggested that universities can play a vital role in promoting healthy behaviour and in creating healthier communities (Darker et al. 2021), and effective communication is key to these efforts. In Uganda, however, efforts to incorporate health into university processes and functions are hindered due to a low regard for health as an important responsibility for universities.

Although universities should ideally be interested in communicating about health issues, there are numerous challenges to the implementation of effective and comprehensive health communication efforts in Ugandan university campuses.

The challenges discussed in this chapter are not necessarily definitive but provide a good example of what ought to be addressed if health communication and promotion are to be fully incorporated in Ugandan universities. General health communication challenges have commonly been discussed, focusing mainly on the nature of messaging, communication channels, target audiences and strategy. However, institutional factors as drivers of health communication efforts have rarely been discussed. The focus in this chapter is on institutional barriers, which are important, and are broad enough to apply to a wider community of higher education institutions in Uganda. These are also similar in character to those in many African countries.

## **Theory**

### *Beyond biomedical and behavioural paradigms*

A review of Uganda's university health activities in both policy and practice reveals a significant leaning towards a biomedical and behavioural approach to health communication. In this regard, ensuring clinical treatment for staff and students is paramount and personal responsibility for health is mostly placed in the hands of the individual. As Obregon and Waisbord (2012) postulate, communication anchored in this approach is certainly not tailored to reinforce interventions to address social determinants and underlying barriers to health.

The biomedical and behavioural approach has long dominated the field of health and healthcare, but it is not comprehensive enough to address the health concerns of the majority of universities (Macnab, 2012). As may be expected, Ugandan universities put their focus on making medical services available. Then through various fora, students and staff are encouraged to access such services if they require them. Systems are in place at universities to guarantee the provision of clinical care, while enhancing diagnostic services at university hospitals. For instance, Egerö (2006) noted in his article on HIV/AIDS in Ugandan universities that the Makerere University hospital has a long history of efforts to support both students and staff by

providing HIV/AIDS information upon request, as well as making other HIV-related services and tools like condoms, counselling and testing available. He observed that the hospital, at the time of his investigation, was not using the extensive advocacy efforts that the HIV/AIDS crisis demanded and still does not, primarily due to lack of resources.

The current situation has not changed much from what Egerö indicated. In 2018, Makerere created the Makerere University Health Services (MakHS) and increased the range of health services for both students and staff. In keeping with the biomedical approach, the MakHS was not intended to pursue health promotion, education and communication; its mandate is disease prevention and treatment. As a result, the University's focus is on modernising the university hospital as part of the efforts to provide a broad range of clinical and medical services. The University administration continues to urge both faculty and students to use the hospital's services for all their health-related needs.

There is little question that medical care for those on campus should be a top priority for universities, and for health communication. However, numerous other underlying barriers to campus health are hardly addressed and may even be given less priority on university campuses around the country. The emphasis on clinical care and health services in universities constitutes a barrier in three ways:

- It implies a focus on just those who require medical care, and addresses only a narrow range of health issues. Therefore, health communication initiatives that are associated with such an approach are unlikely to have a significant impact on the university community as a whole.
- The other likely consequence is an oversimplification of complex health matters, because it is thought that once people are treated their health is fully catered for.
- Lastly, as previously highlighted, many health issues affecting the university community are not optimally dealt with in this clinical way. Lifestyle, disability, diet, student

housing, smoking and mental health are a few examples of these challenges.

As already highlighted, health communication has for more than two decades moved beyond the focus on individuals in both theory and practice. For example, Obregon and Waisbord (2012) have edited an entire volume on global health communication that asserts that global health and health communication are now more inclined towards the integrative and holistic approach that targets the underlying socio-political drivers of health, sometimes broadly termed the social determinants of health (Dooris, 2013). This shift in health interventions from the promotion of clinical services to addressing the underlying social and behavioural conditions is a fully funded approach to promoting health in developed Western countries (Came & Tudor, 2020). To move beyond the focus on individuals, communication efforts that support a wider university response to health require capacity and expertise to generate partnerships, participation, institutional support, mobilisation of campus community for action to address behavioural and underlying barriers, and the support of different stakeholders (Ray et al., 2023; Sihotang et al., 2024). This would require the use of various approaches to communicating health, including health literacy, health advocacy, health promotion, and social and behaviour change, all of which are not ordinarily placed in hospital settings.

## Literature Review

### *Universities as health promotion settings*

In previous decades, the practice of communicating health has evolved in significant ways, bringing with it the need to pay attention to settings and their impact on health. Settings refer to places where people spend their daily life, including their living and working conditions and the people who may have influence over them in such places (Parcel et al., 2000:87). Settings play a significant role in the health and illness of people, given that health depends on physical, organisational and social contexts. Green et al. (2000) have argued that settings provide the social

structure and context for the planning, implementation and evaluation of health interventions. Settings-based projects for communicating health point towards a fundamental redirection of the theory and practice to focus on institutional and organisational cultures and policies that can enhance health, well-being and sustainability. The notion of healthy settings is generally not new in the global health context, having been underscored under the principles of the Ottawa Charter on health promotion (WHO, 1986). Since then, the recognition of settings as critical to our health and health-promoting activities has ushered in new perspectives that are theoretically and practically relied upon to support healthier behaviours and communities. Thus, the ideas that universities, like other places, impact and are impacted by global health problems, and that they can play a leading role in the implementation of interventions to improve health, have inspired new terms such as 'healthy universities' and 'health-promoting universities' that have become part of the healthy settings vocabulary. These terms, used synonymously, generally refer to the integration of health into university culture, processes and policies (Martínez-Bello et al., 2016).

The healthy universities perspective has been growing in both attractiveness and credence in many areas, particularly in the developed Western world (Darker et al., 2021; Martínez-Bello et al. 2016). Healthy universities are an important issue to pay attention to because unhealthy environments and conditions breed negative effects for education institutions, which can adversely impact the national economy. Unhealthy environments and diseases can reduce the contribution that universities make to national productivity, given that this can easily be lost during times of health crises and disease outbreaks. In the long run, universities lose money and income, which can adversely lower their financial and economic viability, if they are not subsidised by the government or supported through donor funding. Moreover, it is not in doubt that both students and university staff spend a significant portion of their time at the university. Thus, if universities shy away from efforts to support healthier living, it amounts to not just a loss of opportunity to promote health amongst a large proportion of the population. It also has

undesirable implications for the future, given that universities may continue to act as disease transition points through student and staff interaction and mobility. Thus, universities have the incentive to engage in health-promoting efforts that can assist in the reduction of health threats and burdens that affect students and employees, constrain productivity and increase expenditure on healthcare.

Universities that integrate health into their systems rely on creating awareness, advocacy, participation and trust in their campus environments and daily activities (Martínez-Bello et al. 2016; Sihotang et al., 2024; Waters et al., 2011). Health communication has thus been widely embraced for this purpose by harnessing an environment which has the potential for dissemination of health messages and engendering useful engagement (Darker et al., 2021; McDonald et al., 2021; Sarmiento, 2017). Yet, education institutions in developing countries in sub-Saharan Africa often struggle to balance their academic mandate with other socially beneficial initiatives, such as supporting public health. In South Africa, where attempts are being made at the Universities of Cape Town and Stellenbosch, the health-promoting initiatives are only emerging, and are not yet fully recognised in university governance structures nor adequately supported to implement the whole systems approach to health (Macnab, 2012). The increasing number and scale of health crises and problems in African universities now make the examination of health communication as an initiative for achieving healthy educational institutions in the region inevitable.

#### *Communicating health in university settings*

In its basic form, health communication may be conceived as the processes in which information and opinions regarding health are exchanged and debated (Corcoran, 2013). On the other hand, Campbell and Scott (2012:179) define health communication as any effort to enhance people's health through promoting health-enhancing behaviour change, appropriate access to health-related services and support, the development of social capital that supports health, collective action to address health-related barriers, and the development of social policy related to

health. When viewed as the latter, health communication can be a tool for promoting all-encompassing changes in social norms, beliefs, laws, and practices in order to prevent disease and improve quality of life (Bernhardt, 2004). Health communication has changed from an emphasis on cognition, where the goal was to alter individual health behaviours, to more transformative approaches that highlight the need for community-building through grassroots involvement in addressing underlying determinants of health (Campbell & Scott, 2012; Rimon, 2001). Accordingly, attempts to engender dialogue and empowerment to reduce fundamental barriers to health are now what health communication foregrounds. As a foundation for tackling structural impediments to health, more modern models also focus on sustainability and communication that builds stakeholders' capacity. Health communication is essential for university communities to be healthy, as it affects their view of health and supports health-related decision making (Sihotang et al., 2024). In order to shape public response, health communication must engage a wide range of stakeholders and audiences across numerous channels. However, health itself may mean different things to different people. For example, it is often simplistically conceptualised as absence of disease (McCartney et al., 2019). Nevertheless, a more acceptable definition is one that focuses on health as a state of holistic well-being, including the social, cultural, emotional, and physical state (WHO, 1986). Based on this definition, communication seeks to enhance health by assisting people, communities, policymakers, and the general public in embracing and maintaining behavioural habits and policy objectives that enhance health outcomes (Campbell & Scott, 2012). According to Corcoran (2013), communication can be crucial for establishing networks, addressing social norms, and addressing gaps in policies, all of which interact to support individual and collective action for health.

One important feature of health communication as it is used in university settings is that it is anticipated to address not just the behavioural components of health, but importantly the underlying barriers to health. According to Dooris (2002), the settings concept pays attention to issues of sustainability,

equity, and involvement while addressing the ongoing health needs of communities that have been determined through needs assessment. The biological, social, and cultural contexts of health within the larger ecological system should also be taken into account. These kinds of health communication interventions are, at the very least, designed to mobilise leadership and decision-makers' support to overcome structural hurdles in specific health situations.

Communication about health in university settings can take various forms such as health education, social media campaigns, advocacy, peer-to-peer initiatives or a mixture of all these and more. Interventions that focus on health education are typically preferred in universities because they are normally institutionally focused, while social media interventions can reach a wider audience beyond the institution, considering the pervasiveness of the Internet in many parts, including in Africa. Peer-driven interventions are also a common phenomenon in university settings because they are more readily accepted. Globally, health communication interventions implemented within and by university campuses have taken centre stage in improving social participation, building alliances and strengthening communities for health (Darker et al., 2021). This trend is also emerging in parts in Africa, particularly South Africa. Despite these examples, however, health communication efforts that fulfil these roles do not happen always, more so in less-developed countries.

It is also important to consider the appropriateness of health information provided by universities, if it should significantly influence student behaviours or those of the wider university community. For example, scholars have cautioned that all health information disseminated for public consumption must be accurate and reliable (Sihotang et al., 2024), particularly given the rampant prevalence of misinformation. Moreover, and as the case is in all health promotion efforts, university health information is effective if it is tailored to audience needs (Corcoran, 2013). It is crucial to align health information to the specific needs and concerns of the university community, especially as it relates to key health challenges that confront this community. It is also important that such information is easily

accessible and inclusive of the needs of the wider university community, including staff and students. This therefore suggests the need for deliberate university health communication programmes that provide accurate, relevant, accessible and diverse health information in order to promote the well-being of all in the university community.

### *Best practices for university-based health communication*

Literature from across the world has shown a number of best practices for university-based health communication. It has been reported that effective university health communication programmes employ a variety of structured and non-structured sources of health information, particularly to reach a wide university population. Structured sources normally include formal classes, university health centres, health fairs and student health clubs and organisations. Non-structured sources, on the other hand, include peers, the Internet, pamphlets and brochures (Hill-Mey et al. 2015). Structured sources were shown to provide more accurate health information to university communities and were seen to be a more powerful medium of health communication in these settings (Brener & Gowda, 2001). This suggests a need to implement more structured communication programmes and to use more structured sources in communicating health in university settings. Further, it is suggested that university health communication programmes that engage students and incorporate the use of social media and the Internet are likely to achieve more reach and coverage, and implicitly success (Sundstrom et al., 2018; Waters et al., 2011). Both the Internet and social media are key in disseminating reinforcements and cues to health action amongst young people (Yager & O’Dea, 2008). Therefore, using social media can increase access to and use of health information by students. Moreover, considering that young people are vulnerable to a variety of health challenges, communication programmes that address multiple health topics in tandem are reported to be more appropriate in university settings (ACHA, 2014). It is reported that university students are often interested in receiving health information on a variety of topics from their institutions (Griner et al., 2021).

In Uganda, there is a dearth of evidence on what deliberate and planned programmes universities deploy to make health information and communication accessible and usable for maintaining a healthy university community. This argument can be supported by recent studies that evaluated the state of student health in higher institutions of learning in the country (Byamugisha et al., 2006; Nalwanga et al., 2021). It is argued that health information and communication strategies are implemented only as part of rare efforts by researchers or university hospitals aiming to address particular diseases (Nalwanga et al., 2021). Other studies point out that university communities, especially students, often lack adequate knowledge and information about health, and their ignorance about health was the main reason for their failure to engage in health-promoting behaviour in the past (Byamugisha et al., 2006). At Makerere, experience has shown that students receive health information only when they go to the university hospital for check-ups and treatment, when they visit the counselling unit or when the university hospital conducts occasional drives to respond to health outbreaks. Such a scenario not only points to the lack of clear guidelines on how to implement health programmes, but also suggests a reliance on ad hoc, disjointed, and intermittent efforts to improve the health of campus communities.

## Method

Methodologically, this chapter relied on qualitative research (Byman, 2016), which comprised primary and secondary sources of data collection. First, document review, including analysis of online information, was carried out using all available Makerere University health policies and guidelines on various health issues, including HIV/AIDS, mental health, student welfare and COVID-19. Key websites, including those of the Makerere University's Health Services and Public Relations Departments, were analysed for health-related information and guidelines. These were considered because they are important sources of health information and avenues for communicating health in the University. Secondly, in-depth interviews were conducted with one key health personnel member in the Makerere Health

Services Division, one public relations officer, one college communications officer, one member of the academic staff, one member of the University support staff and a student leader. This helped to obtain a detailed understanding of the University and its communication policies and practices that pertain to student and staff health. The information obtained was analysed thematically, with the aim of describing the complexities of communicating health in order to inspire a health-promoting campus. The findings from the analysis are explained in the next section.

## **Findings and Discussion**

### **Challenges to communicating health amongst universities in Uganda**

#### *Competing communication contexts*

Establishing communication offices in academic institutions to act as sources of information on all issues concerning the university is a long-standing tradition held all over the world. In Uganda, the context in which the university communication function is embedded constitutes a barrier to implementing information and communication to support response to health in academic institutions. To begin with, the central communication offices, roles and structures of the majority of Ugandan universities are steeped in public relations — an area distinctively different from health communication. This is not to suggest that the public relations function does not serve important health communication purposes. For example, it can help in the marketing of healthcare products and services. Springston and Lariscy (2003:540) have also argued that public relations in health is useful for creating positive public opinions for health causes in order to influence health policy reform and legislation. In Uganda, however, much of the communication that takes place in academic institutions primarily serves institutional visibility and reputation goals, most of which have nothing to do with the promotion of health within and outside the university. For example, it is not uncommon for university stakeholders, including staff and students, to

know more about scientific findings and innovations, which are publicised through self-promoting public relations efforts, than they do about health initiatives in the same institutions. Public relations offices themselves are rarely a credible information source on health matters in the university.

In Uganda, little is known about the role of the central communication offices of universities as regards supporting health; they rarely give attention to health initiatives. For example, although the Makerere University hospital has existed for decades, it was only as recently as 2022 that it collaborated with the University Public Relations Office to establish a forum for communication on campus health. An online application, the Makerere Reproductive Tract Infections (MakRTI) is now underway, which will link the university community to health information, guidance and counselling services for purposes of enhancing sexual and reproductive health on campus. Moreover, the low level of engagement about university health contrasts with the scale of communication about the scientific achievements and innovations of universities and sometimes their individual scientists and staff. This lack of focus on health matters is surprising, given the number of health challenges and issues that confront Ugandan universities, and also the level of information reported in both the media and academic publications about health interventions in universities elsewhere in the world.

Relatedly, the communication staff in many of the university communication offices are not always qualified in health communication: they are rarely trained nor professionally prepared to design and handle health communication interventions. Edgar et al. (2003) have discussed this dilemma and its impact on the visibility and credibility of the health communication. They argue, for instance, that there are very few communication professionals who are appropriately trained for this job. Many are trained in journalism and specialise in media relations, while others possess degrees in communication and claim to understand the field of health communication. Although the staff in many university offices are not trained for health communication, when the need arises for universities to engage in communicating health-related information like the case was

during the COVID-19 pandemic, they are called upon to take up the task. This often leaves them confused as to how to conduct health communication with meagre budgets and experience, if any.

To solve these challenges, Ugandan universities need to recognise health communication as a distinct approach from others like advocacy, profile-raising, public and media relations so that, ultimately, health communication is not grouped with organisational communication and public relations efforts. Ugandan universities must particularly respond to and evolve with the changing demands and necessity to engage in health communication activities for the benefit of university communities that go beyond protecting the corporate image of their institutions.

### *Diverse health and epidemiological issues*

Another important barrier to implementing health communication is the increasing number of health challenges facing universities in Uganda. As already highlighted, the health status of universities in the country is an issue of concern, especially now, when the number of health issues that afflict universities in the country have increased. The numerous health issues, coupled with the dwindling resources and health budgets, make it difficult to make health communication and promotion a priority. The prevalence of many health issues also means that universities need to plan systematically to coordinate all efforts geared towards improving students' and staff health within the most appropriate time. Yet, in many cases, communication to support health interventions in universities is implemented in a reactionary, ad hoc manner specially to respond to emergent outbreaks and crisis situations. Thus, it becomes difficult to design and implement strategic health communication to address ongoing or persistent health challenges.

Moreover, each health issue presents its own communication challenges. Additionally, the health information needs for the different categories of people in the university vary – for example, based on gender and on whether they are students or employees. Thus, communicating about health in a university

setting must be an ongoing effort to support decision-making at different levels and stakeholders. There is also a need to develop a health communication framework for particular universities and perhaps for the entire university sector to support the development and implementation of communication efforts. This is currently non-existent. Another crucial element is that universities might need to develop relations with other partners, including the establishment of linkages between university health services and other units of the university such as communication, medical and public health training departments to support shared actions that everyone on campus can participate in to support a university-wide response to health.

*Lack of clarity of vision for health*

All university functions and activities such as learning, research, community outreach and communication are typically supported by and implemented within a known policy framework. A health intervention that is not supported by clear policy guidelines can be difficult to implement within a restrictive environment such as a university. This is key, because without a policy directive, health interventions can suffer from a lack of credibility and support, and institutions wishing to implement initiatives can suffer from a lack of strategic direction. There is evidence that school health interventions are more successful when they receive policy support from the institution (Macnab, 2012). The universities in Uganda lack a serious and coherent strategy to tackle the health of campus communities and the underlying causes of health crises, let alone health communication.

The policy environment that pertains to health in all universities is outdated, weak, disjointed and sometimes undocumented. For example, a review of health policies at Makerere University shows that before COVID-19, the university had last established a health-related policy in 2008, when it designed and approved its HIV/AIDS policy. This was enacted during the peak period of the field era of health communication, which focused on outreach, the distribution of HIV prevention products as well as information, education and communication (Rimon, 2001). Accordingly, the emphasis in the policy was on the

pivotal role of health workers, and the distribution of condoms and information to students. The implementation of this policy did not focus much on the use of communication to influence social norms and systems within the university to facilitate both individual and social changes required for health. Today, Ugandan universities hardly implement policies to protect both staff and students against the harmful use of alcohol and drugs, or that address the needs of disabled students or implement mental health initiatives in the current context. The university units charged with implementing health-related communication initiatives to influence individual and collective behaviour on campus lack sufficient human and financial resources to sustain communication and health promotion programmes. Finally, all health policies in the universities can only work best if they are consolidated into one university health policy for ease of reference and for addressing health communication and health promotion of the university holistically.

### *Inadequate funding*

Resources, both financial and in other forms, are especially important in the planning and conduct of health communication. The size of the financial resources and wealth that a university has is an important factor in determining the speed and scale with which it engages in health-related communication (Quiroz Flores et al., 2021). As is the case with many other functions and activities in the university, the implementation of health initiatives depends on the resources made available for this purpose. In many universities, however, health as an area is under-resourced. For example, unpublished data from the Makerere budgetary unit shows that the university spends less than 5% of its total budget on health and a significantly small portion of that on health promotion in particular. Uganda's central government is a major source of the public university finance budget. It should be noted that Ugandan public universities have since the late 2000s operated tight budgets, and none has the capacity to spend on non-teaching priority areas such as health. Indeed, Teferra (2003) contends that the economic state of most African countries means a steady decline in financial resources for universities, resulting in

funding levels that in real terms do not match the requirements of critical areas like health. This means that the quality of health initiatives, including health information and communication in these universities is affected.

Moreover, public universities in Uganda have no autonomy, which includes financial autonomy, given that they are all public institutions which are governed as state departments. Prior to the late 2000s, Ugandan public universities relied heavily on internally generated funds, but this is no longer the case. Even though they were not able to adequately implement programmes, this became even harder when the government of Uganda moved to take full control of all funds generated by public universities, mainly through fees collections and projects. Moreover, the neoliberal policies that have been implemented in Uganda since the 1980s have meant that Uganda, like other African countries, started to spend less on higher education in general. Between 1985 and 2005, for example, the Ministry of Education allocated no more than 11% of its budget to higher education, compared to the 60% that was allocated to pre-university education (Kasozi, 2016:87). These trends have not changed much in the last decade, as the education budget in the country has continued to shrink. Kasozi argues that universities in Uganda are mainly viewed as teaching institutions, and therefore the government allocates very little to anything outside teaching. As a result, universities themselves have started to see important priority areas such as health, as a luxury, which further weakens any possibilities for investments in health promotion and communication.

Clearly, the lack of funding for health initiatives is a big obstacle and is disastrous for the designing and implementation of health initiatives to benefit university communities. The current funding policies at universities in Uganda have not facilitated the acculturation of the healthy university approach that is common in universities elsewhere in the world. In general, although the health of the university is important and is accordingly acknowledged, realities indicate that priority is accorded to teaching-related needs. The consequence of this has been the failure to create effective health-related efforts and services, including health communication.

### *Misinformation and fake health news*

The communication landscape has changed dramatically, for better but also for worse, over the past three decades. Arguing from the point of view of health information sharing and transmission, the Institute of Medicine (2002) has acknowledged that the current new media world has many potential and real benefits but that dangers also exist. Misinformation and fake health news are at the forefront of the vices that have come to be associated with the new communication applications and technologies propelled by the Internet. Young people, who are the majority on university campuses, now have access to a vast amount of information, some of it beneficial, some less so. Inaccurate information travels much faster than accurate information, because the digital avenues through which it travels are more pervasive. As a result, young people now have access to a lot of misinformation, including on health matters. Misinformation diverts them from the right health information that can enable them to make the right health decisions.

The proliferation of misinformation and fake news has several implications for efforts to communicate health in universities:

- Some sources of online health information are likely to contradict official positions in a manner that discourages students and staff from consolidating positive health behavioural patterns.
- Fake health messages are more difficult to control, because rumours are more difficult to combat in institutions like universities where the limited health and communication staff have less time available to aggressively follow up each message.
- It is challenging to deal with fake news in an organisational setting in the absence of clear guidelines on how to handle it when it emerges from within. For instance, during the recent efforts to encourage both staff and students to vaccinate against COVID-19, Makerere University came under intense anti-vaccination rhetoric from its own staff, who were opposed to mandatory vaccination. While the

group were able to freely send emails using the central university emailing list to all staff, there were no efforts by the university management to counter or correct the anti-vaccination messages that trended for months on the central communication system. The same applied to Mbarara University of Science and Technology, another public university, when one of its renowned professors announced his discovery of a COVID-19 cure drug called *Covidex*, that went on sale unabated through the country, even without approval from the World Health Organization.

## Conclusion

Communication to support health can be both essential and challenging for universities. This chapter has discussed the challenges faced by universities in communicating health information to their communities. While universities around the world play an important role in maintaining health amongst the university population, there is a need for African universities, especially those in Uganda, to prioritise health communication in order to contribute to healthier campuses. The challenges faced are mostly institutional and require a shift in policies and practice to integrate health as well as health promotion and communication. Reflections about the Ugandan context indicate that the deployment of health communication can help to overcome barriers to health by targeting not just individuals but also by building partnerships, alliances and participation for addressing underlying barriers. These lessons can be applied to several sub-Saharan African contexts within the higher education sector, that do not prioritise health promotion in their environments. Therefore, health communication that goes beyond information dissemination to include health literacy, advocacy and health promotion can play a vital role.

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## Chapter 6

# Multilingual communication, Multimodality and Multivocality as Enablers of Information Access: Teenage Pregnancy Interventions in South Africa and Lesotho

Konosang Sobane 

### Abstract

The deluge of teenage pregnancies has become a global concern given the many challenges that are associated with teenage pregnancy. The escalating trends of teenage pregnancy in the Southern African Development Community (SADC) region and other countries on the African continent have brought to light the need to rethink ways in which communication strategies on sexual health and reproductive rights can be designed to effectively “speak” to the youth and address their needs. In particular, there is a need to focus on multi-faceted inclusivity to address all sectors of the youth population. Most of the available communication interventions have been informed by scholarly theoretical frameworks, global guidelines, national and regional strategies and have used tools and platforms that do not appeal to the youth. They have also overlooked the value of co-creation with the target communities and the incorporation of indigenous knowledge and languages. This is despite the well-known multilingual nature of African communities and the widely acknowledged socio-economic and social dynamics of information access in Africa. This chapter explores some of the characteristics of an effective teenage pregnancy intervention strategy. It looks specifically into how the lenses

of inclusivity, multivocality and co-creation can be harnessed to enhance the reach and impact of messaging in these strategies, drawing examples from Coronavirus 2019 disease (COVID-19) communication experiences in Lesotho and South Africa.

## **Introduction**

The Southern African region is marked by some of the highest adolescent pregnancy rates. Kassa et al. (2018) note that one in four women between the ages of 20 and 24 years bears a child before the age of 18. A UNICEF report (UNICEF, 2020:5) indicates that many adolescent girls and young women aged between 15 and 24 become vulnerable to unplanned pregnancy, and complications related to early pregnancy and childbirth. Common complications of early motherhood include poor maternal and child health as well as higher levels of maternal mortality. While there are many factors that contribute to teenage pregnancy, it has become apparent that ineffective sexuality education and compromised access to information on sexual reproductive health services are key. Various communication interventions have been implemented (Mabeleng, 2019; Letsie, 2021; Reddy et al., 2021), but the scourge of unplanned teenage pregnancy continues to escalate, implying that there is a critical need for more strategic innovations and critical thinking in developing communication interventions for the youth.

In Lesotho particularly, teenage pregnancy is higher than in most countries in the region, estimated at 19%. 56% of these pregnancies are unplanned and they occur amongst women of 15 to 19 years old. This is attributed to various factors, including limited access to and use of sexual and reproductive health services and contraceptives amongst sexually active adolescents. These adolescent pregnancies result in poor educational, physical, economic, and emotional outcomes. These already-existing outcomes are further exacerbated by high levels of stigma and discrimination that is rife in communities, schools, and at homes. Similarly, South Africa has been experiencing escalating trends of teenage pregnancies, especially during the COVID-19 pandemic. Recent reports show that a total of 33,899 births occurred to mothers aged 17 years and younger in South Africa (StatsSA,

2020). This included over 600 children aged 10 to 13 years who gave birth in 2020. Several studies have noted a wide range of health, psycho-social and socio-economic challenges that emanate from teenage pregnancy. A study by Essome et al. (2020) cites health conditions such as toxæmia, anaemia, nephropathy and depressive disorders as possible risks for teenage mothers, while their babies are more prone to conditions such as low birth weight, foetal distress, and neonatal asphyxia. Other socio-economic challenges such as school drop-out have been cited in other research.

Some of the factors that have been found to compound this problem have been noted as multiple sexual partners (Rohmah et al., 2020) poverty and unemployment (Odimegwu & Mkwanzani, 2018) as well as peer influence and pressure (Kanku & Mash, 2010). Regardless of the compounding factors, there is a general consensus that teenage pregnancy is a societal concern that requires a multi-sectoral approach, as noted by Kwacha et al. (2023). Very often, teenage pregnancies are unwanted, and research over the years has consistently shown that a large proportion of them lead to unsafe abortions in an attempt to escape social stigma (see, for example, Fawcus, 2008; McCarthy et al., 2014; Espinoza et al., 2020). This creates further complications for young mothers and in some cases leads to fatalities.

Developing comprehensive sexual health education programmes needs to be done in careful consideration of the fact that in southern Africa access to information is compromised by high levels of poverty, inequality, and unemployment. Programmes should also consider the dynamics of the well-documented digital divide, which refers to the unequal access to and utilisation of digital technologies amongst people of different economic classes (Wang et al., 2023). Added to this problem are high levels of misinformation (SAMRC, 2021) on sexual reproductive health, often easily disseminated and accessed through social media. Research shows that a plethora of novel health education and health promotion delivery mechanisms have so far been tested and implemented. These include using social media or cell phones to communicate with pregnant teenagers; transmitting

reminders about antenatal clinic appointments, and providing relevant health education messages, as well as programmes that capacitate healthcare workers who interact with the pregnant teenagers. The ‘MomConnect’ (DoH, 2024) initiative in South Africa, for example, supports maternal health through the use of cell phone-based technologies integrated into maternal and child health services. According to Sewpaul et al. (2023), the programme uses texts sent via short message service (SMS) to communicate messages about pregnancy and appointments to pregnant women registered on the service. One of the noted strengths of this programme, especially for pregnant teenagers, is that it leverages the increased uptake of cell phone technologies amongst young people, who are a fast-growing population of cell phone users in South Africa.

While these initiatives have been lauded for their success, most of them target teenagers who have already fallen pregnant. There is still a glaring gap in the development and implementation of initiatives that are aimed at combatting these pregnancies before they happen, and there is also a need to co-create interventions with the target audiences, who are teenagers in this case. This chapter explores some of the key characteristics that can potentially enhance the reach and uptake of a teenage pregnancy communication campaign. The chapter discusses the role of intergenerational conversations and multilingual practices in the development and implementation of these strategies. The chapter also explores how multivocality and co-creation can be harnessed to enhance the reach and impact of messaging for teenagers, drawing examples from COVID-19 communication experiences in these two countries.

### Literature Review

#### **Characteristics that define effective teenage pregnancy programs**

The available literature provides evidence of a set of characteristics that set effective interventions apart from others. One of these characteristics is the use of socio-ecological approaches that

address all the factors that account for teenage pregnancy and adopt innovative ways in which the youth can be engaged (Ezenwaka et al., 2020; Tebb & Brindis, 2022). These interventions are based on a holistic understanding of factors that account for teenage pregnancy, as well as systematic assessments of ways in which these pregnancies can be combatted. These factors can include macro-level issues such as the availability of enabling policy frameworks and systems, available information-sharing systems, cultural barriers, and enablers, as well as micro-level issues such as the influence of interpersonal relationships and the socioeconomics of access to information. As part of this ecology, the potential fathers also need to be considered. By paying attention to the local contours of sexuality and the operation of sexuality in different contexts, interventions may have better chances of success in addressing the issue of unplanned teenage pregnancies because they are based on a holistic understanding and are adequately contextualised (Mvune et al., 2019:158).

### **Stakeholder Inclusive Approaches within Prevention Programmes**

Approaches that encourage teenagers to participate in comprehensive adolescent pregnancy prevention programmes and co-create information about the dangers of adolescent pregnancy with them have proved to be effective (Wright et al., 2019). Such approaches amplify the voices of the affected population and encourage peer-to-peer information dissemination. Co-creating content with the affected population makes it easy to develop targeted information and use relevant engagement tools and platforms for that specific audience. Research provides useful information on trends and patterns that can inform strategies, as well as effective messaging on topics such as reducing early sexual activity, reducing unprotected sex, and providing access to sexual and reproductive health services. This information can better be co-developed and effectively disseminated by peers who have the same experiential knowledge and share a context with the target group. With these peer-learning approaches, behaviours such as consistent condom use and use of other contraceptives, seeking information on comprehensive life skills and sexual

health education, and negotiating safer sex with partners can be enhanced.

### **Peer-led Participation and Multifaceted Prevention Programmes**

Peer-led counselling, sexual and reproductive health education, and contraceptive availability have also been found to be effective in increasing adolescent knowledge about sexual health and contraceptive use, thus decreasing adolescent pregnancy (Salam et al., 2016). The value of one-on-one peer counselling sessions is that they become a communication platform that allows for engagements and for the target teenagers to enquire about some of the pertinent issues that they would not have been able to talk about with adults. Counselling performed by peers who have had the same experiences has been found to be a useful tool in HIV/AIDS contexts (Gusdal et al., 2011).

There is strong consensus that effective teen pregnancy prevention strategies should be multifaceted, focusing on delaying sexual activity, especially in younger teens, while promoting the consistent and correct use of effective methods of contraception for those youth who are or plan to be sexually active. In Mississippi, Williams et al. (2015) carried out research exploring effective after-school programmes that can deter students from getting into risky sexual behaviours. They argued for the incorporation of a multifaceted model that includes academic enhancement, recreational activities as well as curriculum-based sex education to curb risky sexual behaviour and teenage pregnancy. For Golman et al. (2019), a multifaceted programme that includes addressing subjective norms, increasing awareness about teen pregnancy rates in communities, educating parents and key stakeholders, and improving policies to support teens and address teen pregnancy-prevention barriers would be more effective. These multifaceted interventions prove successful because they address different layers of the teenage pregnancy problem.

### **Reflective Prevention Programmes**

Developing an effective teenage pregnancy strategy also requires careful reflection and consideration of the theoretical tools and assumptions offered by perspectives of risk and crisis communication theories which describe communication content and practices in relation to the sociological context (Charles et al, 2016), and people's perceptions of their susceptibility to risk. According to Bourrier (2018), "risk communication addresses the risk to a particular condition in relation to future consequences of the condition often before the crisis happens on the one hand. Crisis communication, on the other hand, is an on-going process that occurs during the actual crisis" (Bourrier 2018:3). Effective risk communication increases communities' awareness of their exposure to risk and their vulnerabilities, and also informs them what specific prevention, mitigation and preparation measures they could take. By contrast, ineffective risk communication can lead target audiences to either underestimate risks, which may result in them taking insufficient precautionary measures, or to overestimate them, leading to sub-optimal allocation of resources (Höppner et al., 2010).

These perspectives offer a lens to investigate the value of basing a teenage pregnancy intervention on sound theoretical frameworks. This set of key characteristics is not comprehensive, but it is an indication that developing a communication intervention to combat teenage pregnancy requires critical thought and a deep understanding of the target community. As noted in Maluleke and Troskie (2003), education about sexuality needs to address the multi-dimensionality of a person, including the biological, socio-cultural, psychological and spiritual, as well as the skills to communicate effectively and make responsible decisions. A clear understanding of all these factors informs the ways in which the messages are designed and helps to predict possible enablers and disablers of uptake, and thus the potential effectiveness of the intervention.

**Multivocality and multilingualism as tools for effective teenage pregnancy campaigns: Lessons drawn from observations of COVID-19 communication in Lesotho and South Africa**

In developing teenage pregnancy interventions, it is useful to draw on multiple and diverse voices to convey messaging. COVID-19 messages to the public, each with a specific appeal and potential influence on a particular section of the population, enables communication to reach people with varying socio-economic and demographic characteristics, as noted in Finocchiaro-Kessler et al. (2012). Communication through multiple voices also enables contextualisation and simplification of information, making it more accessible to the public. Benoit-Barné and Martine (2022) argue that a tension exists between the need for organisations to speak with one voice, yet a need exists for them to speak with many voices. They argue that speaking with one voice is a form of multivocality.

At the peak of the COVID-19 pandemic, when there was a plethora of communication activities, Sobane et al. (2020) explored how multimodal communication and language diversity were used to enhance COVID-19 messaging in four African countries, including Lesotho and South Africa. The data for this study was collected through purposive observations of everyday practices and encounters with COVID-19 communication, as well as purposive searches of COVID-19 communication resources in the selected countries' mass media, print media, social media, and online news portals. The social media data sources included Facebook, Twitter, WhatsApp, while other sources included news websites and government website such as ministry of health websites in each country.

Sobane et al. (2020) provide valuable insights into the value of multiple voices in a communication intervention. They show that COVID-19 communication in Lesotho and South involved multiple voices such as the authoritative voice of the government, complemented by those of the media, creatives and civil society, who repurposed and repackaged messaging in different formats to enhance its reach and consumption. Complementing voices that repurpose, repackage, and translate messages are valuable

tools to address the communication needs of target groups such as teenagers. Teenage pregnancy interventions can benefit from these multiple voices. Below are a few examples of voices that we found prominent in Lesotho and South Africa during the COVID-19 pandemic.

During the COVID-19 pandemic, creative and performative arts such as music, dance, comedy and poetry were used for actively repurposing official messaging and conveying it in different modes that are accessible to different population groups. These artistic forms convey messages through modes like audio-visual and body language to give audiences a contextualised communication that they can easily relate to. If adapted for teenage pregnancy interventions, such messages have increased potential for reach and uptake by teenagers. Some of the examples in Lesotho and South Africa included:

### **Music and dance**

Music productions widely disseminated as music videos on social media were found to be popular for disseminating COVID-19 messaging on behaviours that can mitigate the spread of the virus, using local languages. The music videos entail different aspects of body language that make the messages appealing to the target group and have the potential to foster in-depth understanding and uptake of the messages, as revealed in the examples that follow.

In South Africa, there were several music productions with translated subtitles in multiple local languages, an inclusive and multilingual approach that caters for the communication needs of people with diverse literacies. Also, the use of captions and subtitles assists in the understanding of the message that is communicated and increases the chances of message uptake by the viewers. For example, the Ndlovu Choir, a traditional music group from Limpopo, released a song in isiZulu that explained some of the basic guidelines for combatting COVID-19. The video enjoyed significant viewership figures, since isiZulu is spoken by 25.3% of South Africans (StatsSA, 2018). The video was widely published online and social media platforms such as Facebook

and YouTube, with translated subtitles, as seen in the video screenshot below.



**Figure 1:** Ndlovu singers performing the Corona Song

Beyond the multilingual feature, the body language in the videos was intensely expressive and complemented the lyrics, thus creating an entertaining communication tool that many people could easily relate to. In another production, a group of about 30 medical doctors calling themselves ‘SA GP Collaboration – Voices that Care’ (Grobler, 2020) recorded an inspiring song about COVID-19 and disseminated it on the Zoom platform. This collaboration marked the strength of networking and solidarity and had a better chance of inspiring behavioural change due to the multiple faces and voices that appear as agents in the video.

### Poetry

Some of the messaging was disseminated through poetry. This creative expressive form of communication is well-known for conveying emotions while also appealing to the feelings of the target audience. In Lesotho, three poems about COVID-19 were posted on social media, conveying safety messages. The social media dissemination was a move to enhance their reach and visibility and, in turn, the potential impact of the message.

In these poems, the poets create a representation of the virus as a monster to convey its danger. In the first poem, the virus is construed as a *Kholumolumo*, a Sesotho word that refers to a mythological creature found in Sesotho folklore, often describing a huge dragon or dangerous monster (Peyre de Fabrègues & Allain, 2019). In the second poem, it is described as *Obe*, a popular scary

monster commonly found in Sesotho folklore. This portrayal of the virus as a scary animal is meant to evoke fear of the virus while influencing the adoption of behaviour that will combat infections. In addition to these message frames, the poets use a sad tone and a combination of sad, fearful and angry bodily gestures to drive home the message on the danger of the virus. In the case of these poems, message reach and potential impact is enhanced by the use of local languages, the multimodal nature of the poems, the dissemination of the poems on social media, as well as framing the message with a fear appeal frame.

### **Comedy and drama**

This period has seen a rise in the number of independent comedians using YouTube to disseminate content to inform and entertain their audiences. In Lesotho, a five-episode comedy series on COVID-19 was commissioned by the government through the National Emergency Command Centre, a strategic body that guides the government's response to COVID-19. The series conveys messages about the danger of the virus and measures that can be taken to minimise the risk of infection and offset the spread of the virus, by exploring fictional storylines of the effects of COVID-19. These videos, disseminated on a dedicated Facebook media page of a Lesotho stand-up comedian, Lilaphalapha, become a communication initiative that could easily appeal to local Basotho because of the familiar characters, their physical appearance, as well as the physical location portrayed, a rural setting which many Basotho could relate to since it was part of their upbringing, as depicted in Figure 3. The same initiatives are seen in South Africa, where a famous YouTube character known as *Mhlonishwa*, well known for using a bit of comedy to address societal issues, has produced a series of videos on COVID-19 messaging.



**Figure 3:** Courtesy of Lilaphalapha media productions in Lesotho

The comedians combine expressive facial expressions and body language, body movements, demonstrations, gesturing and blending of languages to disseminate messages in a humorous yet informative way.

These complementary voices, often co-created with the target population, have been recommended in crisis communication since they have a potential to produce “high quality community-related information” (Nisbet & Scheufele, 2009:1775). For teenage pregnancy, which is a crisis at present, intensifying interventions that involve artistic voices will go a long way in driving the uptake and impact of communication amongst teenagers.

## Theory

Theoretically, literature advocates the social disorganisation theory in developing teenage pregnancy interventions. According to Mkhwanazi (2017), social disorganisation is defined as the inability of community members to achieve shared values or to jointly solve the problems that emanate within the household and society. The theory implicitly advocates for the inclusion of moral values in sexual health education. Mkhwanazi (2017) further explains that the theory specifically helps to understand why teenage pregnancy is higher in some households and communities than in others as well as what the household- and the community-level variables within such contexts are (above and beyond individual-level characteristics) that foster teenage pregnancy in South Africa (Mkhwanazi, 2017:49). When there is adequate understanding of the specific contextual factors that

account for teenage pregnancy, messaging in a communication intervention is framed to also account for such factors and is therefore more contextually relevant.

## Discussion

### **Intergenerational conversations on safe sex and teenage pregnancy as a resource to be leveraged**

Available research shows that open intergenerational conversations on sex and sexuality education between adults and teenagers are an important avenue in curbing teenage pregnancy (Mkhwanazi, 2017; Mudhovozi et al., 2015). According to Mturi (2015:2), premature pregnancies can be avoided by improving parent-daughter communication on sexual matters earlier in life. This is because research has shown that although other influencers such as peers and multimedia are also largely at play, adolescents' attitudes towards sexuality and part of their sexual behaviours and activities are to some extent influenced by the sexual values that parents exerted on them, and their communication about sex with their parents (Mudovhozi et al., 2012). This implies that where there is good and informative communication between adults and teenagers about sex, such teenagers become equipped with information that helps them in decision-making about safe sex and becoming sexually active, and are therefore equipped to avoid unplanned pregnancies. Adults' experiential knowledge becomes an important tool that can be harnessed in conceptualising efforts to communicate to teenagers about teenage pregnancy.

On top of experiential knowledge, parents and elders are seen as a source of indigenous knowledge which teenagers can learn from. This includes knowledge of indigenous cultures and practices that can help teenagers effectively manage the sexual changes that happen in their bodies (Fershtman et al., 2011), as well as taboos and avoidance practices that delay sexual activity and help teenagers to manage it (Bhochhibhoya et al., 2024). Because of this, there is great value in creating partnerships between adults and teenagers in sex education. This is echoed

by Maluleke (2007), who advocates for the promotion of these partnerships in sex education to ensure that young people make informed choices. According to Maluleke (2007), a wealth of indigenous knowledge for teenage pregnancy prevention is available in most communities and can be passed to young generations if it is fused into adult-adolescent communication and in the design of sexual health promotion interventions. Communicating and engaging teenagers with this indigenous knowledge ensures that teenagers access a diverse range of pieces of knowledge and that their decision-making is informed by different knowledge bases.

Despite this widely acknowledged value of adult-teenager communication and engagements about issues of sex and sexuality, Makiwane (2010) finds that this kind of communication is still very scarce, resulting in a gap of information amongst young people in South Africa. This is conceded to by Mothiba and Maputle (2012), who attribute this gap to parents' reluctance to make sex education and contraceptives available to their teenagers or engage their teenagers about sex, because of the fear that their teenagers might interpret that as permission to engage in sexual activities. Another communication challenge identified by teenage pregnancy intervention research goes back to issues of stigmatisation of teenage pregnancy that makes it somewhat of a taboo topic between parents and teenagers. This stigma not only poses a challenge to communication but also affects teenagers' access to sexual health services. Cooper et al. (2016) established that teenagers face challenges in accessing public sector contraceptive services due to judgemental attitudes from many healthcare providers for being sexually active.

### **Drawing from cultural and indigenous practices in conceptualising teenage pregnancy interventions**

Any efforts to develop communication interventions should draw from the existing practices and norms of the societies they target. In most rural African communities in Lesotho and South Africa, there is a practice of silence on issues of sex and sexuality in families. According to Ramathuba and Mashapa (2019), in such communities these topics are not openly discussed, especially by

parents and guardians with their young adults. Because parents and caregivers find it difficult to talk about this, Mudhovozi et al. (2012) note that most communities have historically developed platforms and practices in which adolescents are educated about sexuality. Such practices include initiation schools where senior members of a family also play an important role in educating youth about sexuality. Because of the insider knowledge possessed by those who participate in these, co-produced communication interventions benefit from the knowledge and have more coverage and uptake as noted in the work of Maluleke (2007).

Culturally centred approaches are also advocated for because very often culture determines how people react to and consume messaging. In resonance with this, Dutta (2015) confirms that culturally centred approaches enable communication interventions to consider structural determinants of health and move away from reductionist approaches that propagate shame and disgrace for teenage pregnancy and motherhood. In multicultural contexts such as Lesotho and South Africa, culturally centred approaches require meaningful engagements and intercultural dialogues that may need to include voices that have traditionally been excluded (De Palma & Francis, 2014).

Indigenous knowledge systems carry a wealth of knowledge that can be harnessed to inform contemporary interventions. Seroto (2011:79) explained that indigenous education in Africa was practised in two ways: firstly, informally through parents and elders in society through a socialisation process, and secondly, formally through initiation rites or apprenticeship / craftsmen. Initiation rites and various rituals to mark the passage from childhood to adulthood were cultural devices that were used to inculcate the spirit of communalism in the youth. An initiation ritual includes any system of rites that are done regularly in a set, precise manner whereby a child or adolescent is made a member of a sect or society and invested with a particular status (Seroto, 2011:80). In this paper two specific indigenous practices are of interest: the *Vukhomba* puberty rites amongst the Vatsonga as discussed in Maluleke's work, and the *Thakaneng* practice of Basotho as collected in ethnographic discussions with four women from Piting Ha Tumo, a rural area in Lesotho.

### **The Vukhomba**

Maluleke and Troskie (2003:48) studied *Vukhomba* passage rites of teenagers according to the views of Vatsonga women in Limpopo Province. According to this study, *Vukhomba* refers to the traditional rite of passage for girls, which takes place amongst the Vatsonga / Machangana exclusively for a girl after the first menstruation. The family decides when they would want their child to go for the rites. *Vukhomba* happens any time after the first menses, for example, a week, months or even years later, depending on the family. It is a period of seclusion, and this is referred to as being in the hut. The key feature of the practice is that it is a period of mentorship for the girl to be prepared for being a fully grown woman. According to Maluleke (2003) each girl has about three mentors during this period:

- The *mudzabi*, who is responsible for the entire needs of the girl and is a partner to the initiate;
- The *Murileri*, who is the person the girl confided in when she realised that she was menstruating;
- A *vukhomba* elder, who comes from the royal house to supervise the rite, and is usually the traditional leader's wife, mother or sister.

The role of these mentors, according to Maluleke (2003), is to shape the initiate into womanhood in accordance with the expectations of society, with an understanding that she has reached sexual maturity as well. The following are some of the sexual education content that Maluleke (2003) observed:

- personal hygiene,
- maintaining virginity,
- self-control, and
- social morals.

Although avoidance of teenage pregnancy does not feature in this list, these topics all subsume avoidance of unwanted pregnancy (with personal hygiene perhaps doing so less directly).

### **Thakaneng of Basotho**

*Thakaneng* is a place where girls who are deemed to be sexually mature sleep together at a particular home selected by the village chief. Such a home should have a woman of good social standing and good morals in the community. The girls commune there every night and according to the key informants there were two reasons for this:

- to subject the girls to informal education that prepares them to be women in all aspects of life
- to remove them from their parents' house so that they do not get to hear or witness their parents' sexual activities.

This practice was reportedly a good platform that relieves parents of the burden to discuss sexuality with their children because that was somewhat of a taboo topic.

While the education is the prerogative of the selected woman, she is able to informally enlist the assistance of other women of a good calibre to educate the girls. According to these key informants, the following are some of the topics that used to be covered:

- Maintaining virginity,
- Self-control,
- Understanding themselves as ambassadors of their families and thus of the communities, and therefore an unwanted pregnancy will bring shame to all these,
- Key considerations in choosing a man to marry, such as family background, economic strength etc.

This practice faded away with modernity, yet informants feel that it was very effective in controlling teenage pregnancy because girls were conscious of not embarrassing their educator, their peers and society at large.

These two practices were selected to represent many others in South African indigenous communities that have the same characteristics. Most of these practices are still performed and they do hold in them a wealth of information and platforms that have been time-tested for resilience. Although they may not

be practicable in urban environments, much can still be drawn from them.

### **Lessons to be drawn from the two indigenous practices**

*Adults taking an active role in education and mentorship:* In both practices selected adults take the responsibility of educating the younger generations. Previous sections have indicated that there is a wealth of experiential knowledge that is in the hands of the adults and that could benefit the younger generations. In particular, a community system that sees women with specific qualities being mentors would be a particularly valuable resource.

*Strengthened community systems:* The two practices show the existence of established community systems and have been operating in communities for a while. There is a need to have such systems to combat teenage pregnancy. When such systems are established, they enable a multi-sectoral approach to addressing a problem, and the development of a context-specific intervention.

*Communal learning:* The fact that the girls learn together as a group means that they are given a platform that makes them accountable to each other. There is mutual learning from their peers, while they are also able to hold each other accountable. That strengthens the extent to which they apply the knowledge they learnt.

## **Conclusion**

An effective way of designing a communicative strategy that would curb teenage pregnancy is to take into consideration factors that influence families, the environment of schools in the area, peers and partners from that community. The strategy should also consider structural barriers influencing young women's experiences, behaviours and perceptions of how they think about their sexual and reproductive health. The major contextual factors contributing to these barriers are related to economic disruption and poverty, loss of family structure and cultural and societal norms governing the role many young women are expected to fulfil. An additional problem is the increased acceptability of intimate partner violence in exchange for economic benefit. The

neglect of social and structural predictors of teenage pregnancy has led to its continued persistence. This chapter has pointed to the potential of using indigenous knowledge that emanates from the socio-cultural environment in designing communication interventions to address teenage pregnancy.

Given the low literacy levels and lack of access to information amongst teenagers in both Lesotho and South Africa, alternative and innovative communication approaches need to be considered. This chapter suggests the incorporation of the perspectives of linguists in developing interventions would be considered. This is because they have the ability to understand pertinent linguistic issues that have a bearing on access to and uptake of communication amongst teenagers in multilingual contexts. Linguists also often have a grasp of language choices in multilingual contexts as well as the mitigations for the different literacy levels of various audiences. The factors that account for teenage pregnancies in Lesotho and South Africa are diverse and complex. Communication intervention and campaigns should therefore build on the already existing communication ecology to harness the strength of tools, platforms and practices that have already proven to reach teenagers in different sectors of society.

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## Chapter 7

# Indigenous Language Use in Knowledge Dissemination in South Africa During the COVID-19 Pandemic

*Mmakwena Molala* 

### Abstract

During the COVID-19 pandemic the use of indigenous languages became very important for ensuring that health messages and information about regulations reached the public. The COVID-19 Command Task Team formed by the South African President became a national structure that had to work with task teams formed in provinces to ensure the dissemination of knowledge about the COVID-19 pandemic and the measures that government implemented. Knowledge dissemination takes various formats, namely written, spoken, and sign language. It is very important for ensuring that the message reaches the intended audience, that it is well understood and correctly implemented. This chapter explores how indigenous languages were used to disseminate knowledge during the COVID-19 pandemic, and if knowledge dissemination in various languages was adequate. The Diffusion of Innovations Theory was instrumental for this study. A document analysis method was used to explore the focus area and address the research questions. This chapter is of value, as the urgency of the pandemic meant that South African citizens needed to understand the message delivered by government. Learning the lessons from the COVID-19 experience might assist communicators with successfully communicating health messages in future.

## Introduction

Language was a contested issue at the dawn of the South African democracy. The Constitution of the Republic of South Africa, act 108 of 1996, hereafter referred to as the South African Constitution (South Africa, 1996) (Chapter 1, Section 6) recognises twelve official languages, namely Sepedi, Sesotho, Setswana, isiSwati, Tshivenda, Xitsonga, Afrikaans, English, isiNdebele, isiXhosa, isiZulu and South African Sign Language. The Constitution (South Africa, 1996:Section 3a) also states that national and provincial governments may use any particular official language for governance purposes, while taking the use, practicality, experience and regional circumstances into account and balancing these with the needs and preferences of the population as a whole or in the province concerned. However, national and provincial governments must use at least two official languages, while municipalities must take the language use and preferences of their residents into account.

On 11 March 2020, the World Health Organization (WHO) declared that the outbreak of coronavirus disease 2019 (COVID-19) that started in Wuhan, China, was a global pandemic. COVID-19, an acute respiratory contagious disease to which all people seem to be susceptible, is caused by the 2019 novel coronavirus. The scale at which it spread across the world brought fear, anxiety and even panic. On 25 April 2020 the South African President, Cyril Ramaphosa, through legislation, declared a 21-day lockdown, with various measures to limit the spread of COVID-19. The pandemic brought a speedy response and publication of various legislation to ensure awareness, education and preventative measures. The government, public and private sector put in place a participatory and collective process that ensured that decisions were made about data that would be useful and life-serving. The Disaster Management Act number 57 of 2002, hereafter referred to as the Disaster Management Act (South Africa, 2002), was enforced through regulations, with various government departments through their ministries directing initiatives that fall within their legislative mandate. The Cooperative Governance and Traditional Affairs Minister at the time, Dr Nkosazana Dlamini-Zuma, remarked on

22 March 2020 that the regulations "... enable us as government to focus on preventing a disaster and where applicable reduce the risk of disasters, they activate governments capacity emergency preparedness regime, which must be rapid and effective". The President's address to the nation set the tone and gave strategic guidance to ministers in defining and gazetted regulations within their various portfolios to ensure that knowledge was disseminated through various platforms.

Knowledge is defined as the process of organising and arranging information for certain objective (Faladesiani & Senen, 2024:184), within the study knowledge is defined as information that has meaning, and the data collected by the Department of Health in South Africa accordingly interpreted, refined and disseminated to the public. Davila et al. (2006) indicated that "knowledge may be disseminated but the degree to which it is transferred to other is largely dependent on the communication process used, since the acquisition of new knowledge is primarily a communication process". Knowledge dissemination involves infrastructure, process, systems, tools and technologies. In the South African context, the government has all of this at its disposal, and also has processes and systems in place. These include the Disaster Management Act, the Coronavirus Command Task Team, infrastructure in terms of the health facilities (hospitals, clinics, newly developed field hospitals), technologies in terms of media coverage, a website (<https://sacoronavirus.co.za>) and WhatsApp (COVID-19 updates). In this regard, Green et al. (2014:153) comment as follows: "dissemination is not an end in itself, but a distinct process from the implementation process of reinventing or adapting what has been disseminated and working through and around the polices, traditions, culture, and other constraints of the organisational context in which disseminated innovations or policies are to be implemented".

The literature review section explores language use as social action, contextualising language in knowledge dissemination, the composition of languages in South Africa and the implementation of language policy in South Africa. The theoretical framework adopted is the innovation of diffusion theory, which will be used to explore the language used in knowledge dissemination. The

research methodology adopted for the study reported on in this chapter is document analysis: various sources, including policies, journal articles, data from Statistics South Africa (StatsSA) and the Broadcast Research Council of South Africa (BRCSA), were consulted and analysed in relation to the study. Analysis is performed on the knowledge dissemination tools based on data from StatsSA and BRCSA in support of the composition of language and usage in the public domain. This includes the geographical distribution of the South African populations, the languages mostly spoken in South Africa, newspaper readers, and media landscape, including trend analysis for the viewers. The study provides recommendations as per the document analysed and how best in future indigenous language can be used as part of knowledge dissemination, in situations such as the COVID-19 pandemic.

The Bill of Rights, in Chapter 2 of the South African Constitution (South Africa, 1996), states that “Everyone has the right to use the language and participate in the cultural life of their choice ...” In a democratic state, language policy is crucial for the development of a democratic culture and tradition. The outbreak of COVID-19 emphasised the importance of using all South African languages in knowledge dissemination to ensure understanding and compliance by all citizens. The challenge remains whether the two languages used when the President and ministers make important announcements relating to the COVID-19 pandemic is enough. The chapter looks at the importance of using all indigenous languages or official languages in South Africa during the COVID-19 pandemic to ensure that all citizens understand the information disseminated. Section 3a of the South African Constitution states that national and provincial governments may use any official language for governance purposes. In light of the acknowledgement of indigenous languages by the South African Constitution, the following questions are pertinent:

1. Did the information on COVID-19 reach its intended audience properly?
2. How effective was multilingual communication during the COVID-19 pandemic?

3. How effective were communicative platforms as knowledge dissemination tools?

## Literature Review

The WHO's Risk Communication and Community Engagement (RCCE) provides guidelines to member states in terms of the COVID-19 outbreak on how to communicate effectively with their populations (WHO, 2020a). Failure to communicate leads to a loss of trust and reputation, economic impacts, and - in the worst cases - loss of lives. The WHO's RCCE (WHO, 2020a) outlines the following public communication guidelines:

- Identify spokespersons based on the trust they have with the population, the type of message that needs to be conveyed (e.g. about political commitment, technical expertise, health protection) and the severity of the situation.
- Make sure messages are consistent across sectors and levels.
- Share information regularly (ideally each day at the same time of day).
- Share leadership and response decision-making in messages to the public so that the reasoning behind difficult decisions is clear.
- Share stories, photos, and videos that illustrate key messages.
- Ensure that the public knows where to obtain up-to-date information regularly (e.g. on websites, during daily press briefings, through hotlines).
- Provide regular, transparent communication through the channels that the targeted audiences use.
- Use traditional media, the Internet and social media, hotlines, and text messages as appropriate.

To mitigate the effects of the pandemic, countries, including South Africa, adopted the above procedures in public communication. Flexibility was encouraged: each country had its own way of implementing the factors that would ensure that the COVID-19 pandemic was well-managed and contained. Language is not mentioned above, but clearly the guidelines addressed the process that can be used, leaving member states to adopt the method of knowledge dissemination that would be useful for their country.

### Language use as Social Action

Whether language conveys meaning remains an open question (Glenberg & Kaschak, 2002:558). Glenberg and Kaschak (2002:558) remark: “the dominant approach is to treat language as a symbol manipulation system: language conveys meaning by using abstract, amodal and arbitrary symbols (i.e. words combined by syntactic rules)”. The use of language becomes a strong element when content and knowledge are disseminated. Martin and Dowson (2009) argue: “ongoing social interactions teach individuals about themselves and about what is needed to fit with a particular group”. They also acknowledge that “individuals develop beliefs, orientations, and values that are consistent with their relational environment”. The following components of language can be used as social actions:

- **Interpersonal action:** Interpersonal consequences of talk is about the role language use plays in how others perceive us, and we perceive them (personal perception) as well as the topic of impression management – the way we adjust our talk to active special results (Holtgraves, 2013:1), whereas Rusu (2023:220) noted that “interpersonal communication is an important area of human manifestation responsible for the effectiveness of adaptation of the world in which we live”. The use of the language in the COVID-19 pandemic messaging as knowledge dissemination plays an important role, as the authorities appealed to citizens’ concern for their own health and safety. The President’s addresses took the form of appeals to the inner person rather than merely delivering a message. Here, indigenous languages can also play a role if well used.
- **Contextualised action:** Holtgraves (2013) indicates that languages differ in the terms they provide, and personal perception may vary between cultures. Context is therefore crucial to understanding the message.
- **Coordinated action:** The entire operation by the state is a coordinated action to ensure that citizens are safe from an invisible enemy (COVID-19). Language forms a central part of the strategy. In this case English was used, as it is a language that many can understand.

Regarding public health emergencies, Africa needs to recognise that the particular needs of every marginalised / vulnerable group have to be addressed in order to surmount the barriers to the right to health (Adebisi et al., 2020:449). Adebisi et al. (2020:449) note that Africa's public health response has to be more inclusive and needs to be more strategic and proactive in reaching out to specific groups and identifying and addressing their needs. In Ghana during the COVID-19 pandemic, indigenous songs were used to ensure proper knowledge dissemination. Thompson et al. (2021) indicate that "in Ghana apart from the updates from National Commission for Civil Education (NCCE), some musicians in the country took personal initiatives to compose songs in local languages to educate the public about the disease". In Cameroon, the local languages took centre stage in delivering messages during the COVID-19 pandemic, despite the country's official languages being French and English. Delmon (2021:111) states: "COVID-19 has allowed the local languages of Cameroon to supplant the official languages, English and French in their daily use to fight against the pandemic or to prevent the population from the threat . . . to reach the people at the grassroots, local language have been used as a main channel". In Nigeria, the media used local languages to deliver COVID-19 information. Rudwick et al. (2021:2) state that "while Nigeria is divided along ethno-linguistic lines and it is therefore not advisable per any federal political leader to code switch in addressing the press or the media on the issue of COVID-19, there is evidence where media representatives use African languages while Ministers answer predominately in English and/or one of the major Nigerian languages (Hausa or Iqbo or Yoruba)". Language becomes one of the important elements of social action during the COVID-19 pandemic. The urgent situation required African countries to supplement their official languages and use predominantly local / indigenous languages to ensure that knowledge was disseminated and understood by their local audience.

### **Contextualising Language in Knowledge Dissemination**

The acknowledgement by the WHO that COVID-19 was spreading via a pandemic, propelled various governments to act quickly in

terms of preparing their health responses – not only in terms of preparing the health facilities but also ensuring that the message was delivered and understood by the public. In the fight of COVID-19, people’s response took centre stage. In contextualising the knowledge dissemination, various models and knowledge dissemination tools were put in place. Three models of knowledge dissemination were adopted during the COVID-19 pandemic:

- **Linear model:** Knowledge dissemination during the COVID-19 pandemic mostly deployed the linear model, in which knowledge is seen as a product that is packaged and presented to the audience. During the COVID-19 pandemic information had to be disseminated urgently and in accordance with health guidelines. English was used for pragmatic reasons.
- **Relationship model:** To counter the pandemic, relationships become very important. The public needed to trust the government guidelines. Best and Holmes (2010:147) highlight the fact that “relationship models incorporate the linear model principles for dissemination and diffusion, and then focus on the interactions amongst people using the knowledge”. Lomas (2007) indicates that “the emphasis is on sharing knowledge, the development of partnership and the fostering of networks of stakeholders with common interest”. The South African government built relationships with all relevant stakeholders on the national and provincial levels. These included the Coronavirus Command Council, constituted by the ministers in various portfolios, the Ministerial Advisory Committee (MAC), which advised the Minister of Health on COVID-19 recommendations and other bodies constituted to combat the pandemic.
- **System model:** The system model recognises that the diffusion and dissemination process and relationships themselves are shaped, embedded and organised through structures that mediate the types of interactions that occur amongst multiple agents with unique worldviews, priorities, languages, means of communication and operations (Frenck, 1992). In the interactions amongst the stakeholders – the important stakeholders being the communities or public – there is a need to ensure that the message is received

and interpreted and understood accordingly. Fake news or knowledge dissemination is mitigated when recipients receive messages in the language they understand.

### **Composition of Languages in South Africa**

South Africa has eleven official languages. In addition, sign language, San languages and other languages are recognised. During the COVID-19 pandemic, English took centre stage as the official language, with sign language being used to ensure that the hearing-impaired community was catered for. Language usage in South Africa differs according to province, regions, districts and households.

Table 1 shows the percentage of languages spoken by households per population group in 2018.

Table 1 presents a picture of how languages are used and play a significant role in knowledge dissemination and usage. IsiZulu is the most popular language nationally, reported to be used inside households by 25.3% of the population and outside by 25.1%. This is followed by isiXhosa (inside household use 14.8%; outside household use 12.8%). English was sixth (inside households 12.2%; outside households 9.7%). Despite this, English was the main language used during the COVID-19 pandemic for communication and knowledge dissemination to accommodate all South Africans. The understanding of the COVID-19-related messages communicated in English is therefore of concern in this case study. For example, if a household in a rural area of Gama Mashashane (Limpopo) or Mdubaduba (Mpumalanga) has no one competent in English, how can they understand the gazetted legislation on COVID-19 presented by the President and the various ministers?

### **Implementation of Language Policy in South Africa**

Ngcobo (2007) argues as follows: “although language planning in South Africa could be considered one of the best in the world, one may argue that language policy implementation is still the most problematic area of language planning in this country”.

**Table 1:** Percentage of languages spoken by households inside and outside the home by population group, 2018

	Black		Coloured		Indian/Asian		White		South Africa	
	Inside	Outside	Inside	Outside	Inside	Outside	Inside	Outside	Inside	Outside
Afrikaans	0,9	1,0	77,4	68,8	1,3	1,5	61,2	37,2	12,2	9,7
English	1,6	8,6	20,1	28,3	92,1	95,8	36,3	61,0	8,1	16,6
isiNdebele	1,9	1,6	0,0	0,0	0,3	0,2	0,3	0,1	0,6	1,3
isiXhosa	18,2	15,6	1,1	1,3	0,4	0,0	0,1	0,1	14,8	12,8
isiZulu	31,1	30,8	0,3	0,3	0,9	1,0	0,5	0,5	25,3	25,1
Khoi, Nama and San	0,1	0,1	0,0	0,0	0,0	0,0	0,0	0,0	0,1	0,1
Sepedi	12,4	12,0	0,3	0,2	0,5	0,2	0,1	0,3	10,1	9,7
Sesotho	9,7	9,6	0,1	0,2	0,1	0,3	0,0	0,1	7,9	7,8
Setswana	11,1	11,5	0,7	0,8	0,2	0,2	0,4	0,4	9,1	9,4
Sign language	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0
SiSwati	3,5	3,2	0,0	0,0	0,0	0,0	0,0	0,0	2,8	2,6
Tshivenda	3,1	2,7	0,0	0,0	0,2	0,0	0,0	0,0	2,5	2,2
Xitsonga	4,4	2,9	0,0	0,1	0,1	0,1	0,0	0,0	3,6	2,4
Other	2,1	0,5	0,1	0,0	4,0	0,7	1,1	0,5	1,9	0,5
Total percentage	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0
Total (thousands)	46,307	46,135	4,961	4,930	1,430	1,426	4,442	4,420	57,143	56,914

Source: StatsSA (2018)

This problem certainly manifested itself during the COVID-19 pandemic: none of the other 10 official languages was used in the legislation or proclamations, except in situations where ministers themselves translated their speeches using the indigenous languages.

Post-1994, a statutory body, the Pan South African Languages Board (PanSAL), was established through the Pan South African Language Boards Act, number 59 of 1995, hereafter referred to as the Pan South African Language Boards Act (South Africa, 1995), to engage in language policies and planning aimed at promoting language equity, supporting diversity and developing the historically marginalised African languages. PanSal's programmes include the monitoring of equitability of language use and language promotion, which still pose a challenge at the national and provincial level. Most of the publications posted on national or provincial government websites are in English. The Constitution clearly indicates that national or provincial governments have a right to publish in the most preferred language within the country but made provision for the use of two more languages within each province that are spoken by the public.

PanSAL has the duty of ensuring the promotion and usage of the various languages of South Africa. The problem, though, is compliance with the equitability of language use and language promotion. The outbreak of COVID-19 brought forth this important constitutional matter of language and its usage in knowledge dissemination to ensure understanding and compliance. In most of her speeches on COVID-19 regulations, the Cooperative Governance and Traditional Affairs Minister, Dr Nkosazana Dlamini-Zuma used English. She also used some isiZulu, but the media cut most of the isiZulu speeches out. In his general opening remarks at the media briefing on COVID-19 on 20 July 2020, the WHO Director Dr Tedros Ghebreyesus stated: "Although people of all walks of life are affected by COVID-19, the world's poorest and most vulnerable people are especially at risk". He went on to say that "Indigenous people have unique culture and languages, and deep relationships with the environment" (WHO, 2020b).

## **Theoretical Framework**

One important element of the COVID-19 pandemic was that older people and people with comorbidities or underlying illness were likely to perish. Many of these people were disadvantaged, uneducated, in rural communities, and competent only in their indigenous languages. According to Chick (1992:12), “the important challenge is the promotion of the notion of language ecology in which all languages are viewed as national resources needing to preserve and developed so that the talents of their native speakers may be optimally utilised for the good of all”. The Diffusion of Innovations theory was used as the theoretical framework for this study to better understand language usage in knowledge dissemination during the COVID-19 pandemic.

### **Diffusion of Innovations theory**

Green et al. (2014) argues that “diffusion theory represents a long history of attempts to understand the spread of ideas and actions within social systems” and describe the impact of language in public health policy and practice, focusing on the concepts of knowledge dissemination, understanding, utilisation and implementation. Language is of course fundamental to knowledge dissemination. During the COVID-19 pandemic new knowledge and information driven by reports was produced. Legislation and other government blueprints guided compliance with COVID-19 guidelines and measures.

## **Methodology**

A document analysis method was used to gain insight into the research topic and address the research questions. Bowen (2009:27) defines document analysis as “a systematic procedure for reviewing or evaluating documents both printed and electronic (computer-based and Internet-transmitted) materials.” The researcher used both printed and electronic materials: books, journals, articles, online data analyses and media surveys in terms of popularly used languages in the South Africa context. Data was also obtained from StatsSA and the BRC of South Africa to determine indigenous language usage in terms of knowledge

dissemination during the COVID-19 pandemic period. The data considered ranged from July 2017 to July 2020 and provided for population per province and the languages spoken in South Africa.

## Results

### Analysing the Knowledge Dissemination Tools

Knowledge dissemination uses three forms of communication: written material, electronic material and interpersonal communication activities or events. Written material includes articles, booklets, fact sheets, resource guides, newsletters editorials, press releases, posters, news bulletins, policy briefs, and synopses. Electronic material includes email alerts, the Internet, real-time reminders, web conferences and websites, mainstream and social media. Interpersonal communications occur in the form of arts-based performances and various communities of practice.

South Africans access information through different platforms: TV, radio, newspapers, magazines and the Internet. Knowledge dissemination takes various forms: written, spoken and sign language. It plays an important role in ensuring the message reaches the intended audience, is well-understood and implemented.

### *Geographical Distribution of the South African Population*

Table 2 illustrates the breakdown of South Africa's population of 58.8 million (as at 2020) over the nine South African provinces.

**Table 2:** Population per province

Province	Jul 17 – Jun 18	Jan – Dec 18	Jul 18 – Jun 19	Jan – Dec 2019
	,000			
Gauteng	10,2	10,2	10,4	10,4
KwaZulu-Natal	7,7	7,7	7,8	7,8
Western Cape	4,9	4,9	5	5

Province	Jul 17 – Jun 18	Jan – Dec 18	Jul 18 – Jun 19	Jan – Dec 2019
	,000			
Eastern Cape	4,8	4,8	4,9	4,9
Limpopo	3,9	3,9	3,9	3,9
Mpumalanga	3	3	3	3
North West	2,7	2,7	2,7	2,7
Free State	2	2	2	2,1
Northern Cape	0,9	0,9	0,9	0,9

Source: BRC (2020:22)

Table 2 shows that Gauteng province has the highest population. This is driven by economic activities and the migration of populations from the other eight provinces and other countries. It is built on the different cultures and languages of the African continent and beyond. The province is where the eleven official languages are relatively well-understood and spoken. However, the COVID-19 pandemic tested the communication methods used to address the population in the different provinces.

### Languages

South Africa has eleven official languages, with English being used as the main medium of communication by government in terms of disseminating information.

Table 3 presents the languages spoken in South Africa as first languages by percentage.

Table 3 shows that 25% of South Africans speak and understand isiZulu, while Ndebele was the least-spoken language during the period 2018 to 2019. Though English is perceived as the main medium of communication, the table shows that most people do not necessarily speak or understand English. This raises concerns in terms of the information communication flow to citizens by government.

**Table 3:** South African languages

%	Zulu	Xhosa	Afrikaans	English	Sesotho	Setswana	Sepedi	Tsonga	Swati	Venda	Ndebele
Jul-Jun 18	25	15	12	10	10	9	10	4	2	2	1
Jan-Dec 18	25	15	12	11	10	10	9	4	2	2	1
Jul 18 -Jun 19	25	15	11	11	10	9	9	4	2	2	1
Jan-Dec 19	25	15	11	11	9	9	9	4	2	2	1

Source: BRC (2020:22)

**Table 4:** Newspaper readers, population of 15 years +

	Jul 17 – Jun 18	Jan – Dec 18	Jul 18 – Jun 19	Jan – Dec 19
Newspaper readers (thousands)	15,7	15,5	15,6	15,3

Source: BRC (2020)

### Newspaper readers

Newspapers are one of the tools to disseminate information and knowledge, and Table 4 indicates how many people read newspapers. In the digital age news is no longer accessed principally in print form, but on cell phones, tablets and computers (laptops and desktops).

Table 4 illustrates the number of newspaper readers, where the reading population is 15 years or older.

Table 4 shows that out of a population of 58.8 million in South Africa (as at 2020), only 16.6 million read newspapers. Moreover, most newspapers publish in English. During the COVID-19 pandemic it was essential for South African citizens to understand the message delivered by government.

### Media landscape

The media landscape plays a significant role in communication and knowledge dissemination in South Africa and was most commonly used by government during the COVID-19 pandemic.

Table 5 shows the different platforms (in percentages) used by South Africans to access information.

**Table 5:** Media landscape

%	TV	Radio	Newspapers	Magazines	Internet
Jul 17-Jun 18	95	88	39	18	58
Jan-Dec 18	96	88	39	17	61
Jul 18-Jun 19	95	88	38	17	63
Jan-Dec 19	95	88	38	18	66

Source: BRC (2020)

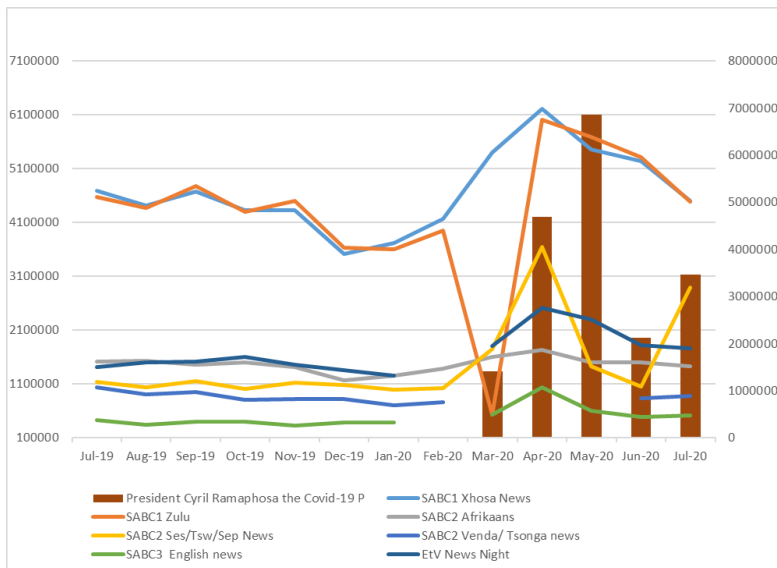
Table 5 shows that 95% of the population used television (TV) to access information and knowledge, followed by radio at 88% during the period 2017 to 2019. The assumption is that during the COVID-19 pandemic, South Africans used TV and radio as the

most common sources of information. The popular language use in the public, commercial community is English.

**Trend analysis for viewers**

It can be observed in Table 5 that 95% of the population uses TV to access information and knowledge and this is also the main platform used by the government to disseminate information throughout the country. Therefore, this section analyses the news trends across the four free-to-air TV channels, SABC 1, SABC 2, SABC 3 and eTV, to determine the indigenous language usage in terms of knowledge dissemination during the COVID-19 pandemic.

Figure 2 shows news audience trends on SABC 1, SABC 2, SABC 3 and eTV during the period July 2019 to July 2020.



**Figure 2:** News audience trends on SABC 1, SABC 2, SABC 3 and eTV. Source: BRC(2020:22)

Figure 2 shows that during the first COVID-19-related lockdown from April to July 2020, people began to watch news on television more. This is perceived as a response to the pandemic and

the desire to know and understand the messages delivered by government. The increase in numbers of viewers show the fear, anxiety and panic brought by COVID-19 and also the desire to seek information on how to stay safe. Figure 2 shows that isiZulu and isiXhosa language news had the largest audience when compared with news in other languages. This is a positive relationship with Table 2, which indicated that isiZulu and isiXhosa are the most commonly spoken and understood languages in South Africa.

Figure 1 also shows that the largest audience (over six million) was observed during the President's address to the nation, regarding various measures through legislation and regulations to combat and limit the spread of the COVID-19 virus. These different channels assisted in disseminating information and knowledge and ensuring awareness and education for preventative measures in response to COVID-19.

## **Recommendations and Conclusions**

South Africa is a diverse country with unique languages and cultures. The term 'rainbow nation' was adopted after the democratic dispensation to acknowledge this diversity. The discussion above allows certain conclusions and recommendations to be made in line with the South African Constitution and language policy. What is abundantly clear from the data presented above is that English was used overwhelmingly in government communications about COVID-19, despite relatively few South Africans being proficient in the language, and isiZulu and isiXhosa being much more widely used. The dominance of English in various domains has led to language shift and the potential erosion of indigenous language, particularly among younger generation (Madimaet al., 2024:11)

The study analysed the knowledge dissemination tools provided by the BRC. The BRC data provides insights into the languages used in the media. The fact that the South African Constitution advocates that national and provincial government should use at least two official languages is encouraging, and the fact that municipalities must consider the language preferences of their residents is important. Prah (2018) argues that "if culture is

the main determinant of our attitudes, tasks and more, language is the central feature of culture”. Culture in South Africa plays an important role in the way messages are delivered and interpreted. Kramsch and Steffensen (2008:20) state that “sociolinguists pointed out that a language is not just a mode of communication but a symbolic statement of social and cultural identity”.

The implementation of the language policy – specifically the raising of the indigenous languages to the level of English – is still a work in progress. Ngcobo (2007:2) indicated that “although language planning in South Africa could be considered one of the best in the world, one may argue that language policy implementation is still the most problematic area of language planning in this country”. The analysis of the BRC data conducted above reveals that even though English is not the most commonly used first language in the country it is still used as the lingua franca – and this was evident during the COVID-19 pandemic. It is also important to note that language advocacy is not well highlighted by the PanSal annual report in terms of usage on government communication platforms. Uplifting the indigenous languages will give them the status they deserve and encourage more usage. In its monitoring and evaluation of indigenous language use, PanSal should ensure that the various spheres of government make greater use of indigenous languages in their official documents.

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## Chapter 8

# Communicating HIV/AIDS Biomedical Prevention Strategies Amongst Young Urban Women: Use of Pre-Exposure Prophylaxis (PrEP) in Kenya and Uganda

Denish Otieno 

### Abstract

In sub-Saharan Africa, the HIV epidemic continues to affect females aged between 15 and 49 years disproportionately more than males. The overall objective of the study was to establish how communication about PrEP influences HIV/AIDS preventative behaviour amongst young women, specifically to establish sources and the framing of PrEP information for young women. The health belief model underpinned the study as well as the two-step flow theory. The study used a qualitative research approach. Convenience sampling was used. Data was analysed thematically and presented in the form of narratives. The study determined that communication on PrEP influences young urban women to accept PrEP. Health facilities act as key sources of information on PrEP. Radio, television and newspapers were found to be reinforcers of PrEP information. Young urban women with multiple sex partners were found to have deeper social and peer-based networks that help to create PrEP awareness. The research findings will likely inform HIV/AIDS advocacy organisations on the importance of communication within social networks in strengthening PrEP discourse.

## Research Operational Terms and Abbreviations

**AIDS:** Acquired Immunodeficiency Syndrome

**Community:** A collection of households that share common interests, usually made up of at least 5,000 people (or 100 households) living in the same geographical area, and normally sharing similar culture, social practices, beliefs, norms and value systems (KNBS, 2024).

**HIV:** Human Immunodeficiency Virus

**KK:** Kisumu, Kenya study participant

**KU:** Kampala, Uganda study participant

**NACC:** National AIDS Control Council

**NASCOP:** National AIDS and STI Control Programme

## Introduction

In Kenya and Uganda, past human immunodeficiency virus (HIV) / acquired immunodeficiency syndrome (AIDS) biomedical preventive mechanisms have attracted extensive media attention. The prominence of health prevention vaccines in mass communication channels have the potential to impact public perceptions of disease-preventive measures. In addition, in recent times, vaccines represent one of the greatest scientific achievements not only in Kenya and Uganda but worldwide in terms of improving life quality and expectancy. However, the public is not always aware of the important role of vaccines such as pre-exposure prophylaxis (PrEP) in preventing HIV/AIDS. Pre-exposure prophylaxis (PrEP) is an oral HIV medicine taken by people at high risk of contracting HIV so as to lower their chances of becoming infected (WHO, 2015). This underscores the knowledge gap in HIV/AIDS amongst the vulnerable population in Uganda in comparison with the vulnerable population in Kenya.

In Kenya and Uganda alike, the introduction of PrEP amongst vulnerable populations (those at higher risk of contracting HIV/AIDS) has been received with mixed reactions. Vulnerable populations, in the context of this study, are groups of people (in this case, young women) whose risk of contracting HIV is situational or contextual. In a radio interview discussing PrEP

efficacy, a female listener asked why a young woman would resort to the use of PrEP, while other callers asked why use PrEP when there are condoms? (DREAMS, 2016).

This chapter therefore highlights how communication of PrEP influences action amongst urban young women regarding HIV/AIDS prevention. In addition, it reveals key sources of PrEP information and how PrEP messages are framed. While there are many types of communication, this chapter discusses interpersonal communication and mass media channels of communication as key in determining how communication on PrEP occurs amongst populations at risk of contracting HIV/AIDS. In this context, the type of communication channel has the potential to generate rich information on PrEP amongst the target population. Information richness is defined as the ability of information to change understanding within a time interval (Humphries et al., 2013). The types of communication used vary in their capacity to process rich information, where richness indicates the capacity for immediate feedback, the number of cues and channels used, personalisation and language.

## Literature Review

### **The important role of interpersonal communication for health**

Wood (2010) defines interpersonal communication as a distinct type of interaction between people that is selective, systematic, unique and processual. It allows people to reflect and build personal knowledge of one another and create shared meanings. Wood (2010) goes on to argue that although it is said that interpersonal communication involves two or three people, the point of focus should be on what happens between people and not where they are or how many are present. Beebe et al. (1996) define interpersonal communication as a written or oral communication that occurs in a one-on-one or group setting. Therefore, it involves people relating in different situations and emotionally connecting. Interpersonal communication has the ability for sustained interactions amongst individuals and groups, unlike mass media campaigns that are typically of limited duration

(Hanan, 2009). In addition, interpersonal communication can be of a delicate and private nature, such as that involved in human sexuality.

Despite the effectiveness of interpersonal communication, there are some weaknesses with this approach. Firstly, interpersonal communication reaches fewer people than mass media. Secondly, interpersonal communication results in behaviour change that cannot be evaluated as easily as creating and maintaining awareness through mass media. Therefore, to overcome the weaknesses in interpersonal communication, mass media communication plays a vital role in behaviour change. Media campaigns can play an effective role in reinforcing interpersonal communication by, for example, focusing on gender roles in the family and community. This has encouraged men to engage in dialogue on HIV/AIDS prevention, rather than placing all the burden of decision-making on women. The importance of families for men and their protective roles in their families and community can be reinforced by mass media, especially in the rural and uneducated communities of Asia and Africa. Additionally, mass media plays a vital role in the dissemination of information to large publics with diverse demographic profiles (Hanan, 2009).

To sum up, media campaigns and interpersonal communication complement each other in the development of communication interventions for HIV/AIDS prevention and care. Mass media can convey information effectively and thereby provides effective support for face-to-face communication. Therefore, as members of a network or community continue to discuss PrEP as an HIV/AIDS biomedical prevention mechanism, its acceptability increases with time. Although it occurs on a small scale, a network of PrEP gatekeepers has the potential to continue to increase over time. Rich communication media enable people to interpret and reach agreement about unanalysable, difficult and complex issues, while lean media are appropriate for communicating routine activities. The effectiveness of how PrEP is communicated and framed, and which sources of information are used remain the primary concern of this paper.

### **Using PrEP in sub-Saharan African contexts**

Pre-exposure prophylaxis (PrEP) is an oral / injectable HIV medicine taken by people at high risk of contracting HIV so as to lower their chances of becoming infected. The Centers for Disease Control (CDC) through its 'HIV Risk Reduction Tool', notes that daily PrEP reduces the risk of contracting HIV from sex by more than 90%. A person's risk of contracting HIV from sex can be even lower if PrEP is combined with condoms and other prevention methods. Despite the evidence of PrEP efficacy and years of programmes to provide it, there is still limited awareness of PrEP amongst the population that is at high risk of contracting HIV in sub-Saharan Africa (Irungu & Baeten, 2020). A number of HIV prevention interventions (biomedical, behavioural, and structural) have mitigated the spread of HIV (Hosek & Pettifor, 2019), but the number of new cases amongst adolescent girls and young women remains unacceptably high (Ajayi et al., 2019).

In 2015, the World Health Organization (WHO) recommended the use of tenofovir-based PrEP in individuals at substantial risk of HIV as part of a combination prevention approach. PrEP can be used discreetly and not at the time of sex – a characteristic that may make it especially important for women, including young women, adolescent girls, and all those who are concerned about acquiring HIV in the context of a stable relationship (UNAIDS, 2015).

Young women and adolescent girls are particularly vulnerable to HIV, and the use of oral PrEP is likely to have a positive impact in reducing HIV incidence rates (NASCOP, 2017; Ministry of Health, 2017). Continuous and intense dialogues about PrEP will lead to an increase in knowledge and awareness amongst adolescent girls and young women, thereby increasing its uptake. This therefore underpins interpersonal communication as key in creating PrEP awareness.

In 2018, of the three million people worldwide at substantial risk of contracting HIV, only 381,580 people were taking oral-PrEP. Of these, only 27% were from sub-Saharan Africa, with the majority of users being adolescent girls and young women (NAM, 2018). According to the AIDS vaccine advocacy coalition PrEP

Watch (2020), by July 2020, an estimated 31,000 to 32,000 people were using PrEP in Uganda, which was lower than the Ministry of Health target of 90,000 at-risk people. Raising awareness of oral or injectable PrEP is a necessary step to increase its use. Lunkuse et al. (2022) posit that knowledge of PrEP is still limited amongst adolescent girls and young women in Uganda.

In Kenya, research indicates that more than half (57%) of all new infections come from eight high-burden cities or regions – namely, Kisumu, Nairobi, Siaya, Homa Bay, Migori, Nakuru, Mombasa and Kisii County (NSDCC, 2021). In 2020, the National AIDS and STIs Control Programme (NAS COP) data revealed that Kisumu had recorded 4,661 new infections, while youths aged between 15 and 24 accounted for most of the new cases. However, according to a study by Ochieng in 2021, there has been a steady fall of HIV cases in Kisumu, Kenya, due to increased usage of PrEP. In Uganda and Kenya, awareness of PrEP is uneven amongst vulnerable populations, and there is also a dearth of literature on how communication influences the attitudes of young women towards PrEP use. This study therefore strives to fill this gap by establishing the sources of PrEP information and their framing.

The overall objective of the study was to establish how communication on PrEP influences the actions amongst young urban women in Kisumu (Kenya) and Kampala (Uganda) regarding HIV/AIDS prevention. The specific objective of the study was to establish the sources of PrEP information for young women and the framing of PrEP information.

## Theory

### **The Health Belief Model**

First developed by the psychologists Hochbaum, Rosenstock and Kegels, the health belief model attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals. The theory is premised on the understanding that a person will take a health-related action if they feel that a negative health condition can be avoided. The theory has four constructs representing the perceived threats and benefits:

perceived susceptibility, perceived severity, perceived benefits and perceived barriers. In this study the health belief model was used to explain and predict how information on PrEP influences the actions of young urban women – that is, if PrEP reduces the chance of contracting HIV/AIDS, is the high-risk population taking health-related actions to use it so as to avoid any negative health condition?

The formulators of the **two-step flow theory**, Katz and Lazarsfeld, posited that information flows in two distinct stages: first, individuals (opinion leaders), who pay close attention to mass media and its messages, perform their own interpretation in addition to actual media content. They then influence the wider population. The effect of a message on an individual depends more on their interpersonal relations to significant others in their networks of family and friends than on their direct exposure to mass-mediated messages. The theory therefore helped in understanding the complexities of how PrEP information reaches and influences certain audiences.

## Methods

A qualitative research approach was used, and this informed the philosophical assumptions, data collection methods, analysis and interpretation. The research used the social constructivist / interpretivist paradigm, which holds that individuals develop subjective meanings of their experiences which are varied and multiple, leading the researcher to look for the complexity of views and rely as much as possible on the participants' views of the situation being studied (Creswell, 2014). Data was collected from young urban women in Kisumu from their natural settings. However, data from urban young women in Kampala, Uganda, was collected via communication with key informants through WhatsApp and Facebook Chat – hence the use of narrative technique in data generation.

The researcher followed the participants' leads and listened to their stories without any interruptions. Multiple data sources from key informants, journals and informal conversations were used to validate the accuracy of the stories.

## **Study Population and Sample**

The study targeted women aged between 22 years to 35 years old and living in the cities of Kisumu (Kenya) and Kampala (Uganda). In Kampala, data was collected from six study participants, while in Kisumu, data was collected from 15 study participants. In addition, data was collected from two key informants. This therefore puts the total actual study participants at 20. Convenience sampling was used. Serem et al. (2013) note that this approach involves using whichever individual (elements) are available to the researcher on a first come, first served basis.

## **Data Collection**

Data was collected through open-ended interviews via the WhatsApp platform and Facebook Chat for Kampala, and face-to-face for Kisumu. Desktop research was conducted throughout pre-field, data collection, research analysis and compilation.

Thematic analysis as a qualitative data analysis strategy was used, resulting in an inductive approach where themes emerged from the data. Thematic analysis is the search for themes of relevance to the research topic under which reasonably large amounts of data from different sources, such as interviews and documents can be organised (Hammersley et al., 2001). During data analysis, the following stages were followed: transcribing data, re-familiarising with the data, first phase coding, second phase coding, third phase coding and product report. Data was presented in the form of narratives.

Even though key informant interviews have been noted to have a limited scope and tend to produce bias either in the selection of respondents or respondents' views, they have advantages, including the opportunity to tap into the deep knowledge of respondents (Mwita et al., 2021). This advantage was relevant to this study, since it wanted a deeper understanding of how PrEP is communicated amongst young urban women and what its influence is. Two key informant interviews were conducted to seek more information on how PrEP is communicated amongst young urban women. One key informant was from Kampala, while

the other was from Kisumu. Both worked for HIV/AIDS advocacy organisations. Convenience sampling was used to gain access to them.

## Chapter findings

### **How PrEP is Communicated Amongst Young Urban Women**

In Kampala, PrEP messages were communicated in English, Kiswahili and Luganda. Most messaging was in the form of flyers (promotional materials) which were available in health centres; messages were also disseminated on radio and newspaper platforms. PrEP messages were however not translated into other local dialects to provide information richness to diverse groups of people. Message content across the platforms include adherence to PrEP, the efficacy of PrEP in reducing the risk of HIV/AIDS infection, forms of PrEP (oral and injectable), and guidelines for usage. Information on PrEP was only prominent in health facilities in the form of flyers, and not through radio, newspaper and television media.

In Kisumu, PrEP messages were communicated mainly in English and Kiswahili, and not in local languages (e.g. Luo), even though Kisumu is a cosmopolitan city. This gap is likely to be the reason why PrEP discourse is not popular amongst diverse groups who may have difficulty in understanding English or Kiswahili. Message content is the same as in Uganda. PrEP information is more available in health centres than on radio and television or in newspapers as popular channels of communication.

### **Sources of PrEP Information**

The study participants revealed that they get to know more about PrEP only when they visit health facilities, where there are information leaflets on PrEP. Participants said that personal networks (friends) and community networks are where they get most updates on PrEP. The information is passed down by those who have visited health centres, because of the fear of having contracted HIV/AIDS from their partners after having unprotected

sex. The danger of this is the possibility of misinterpretation of PrEP information by those who have visited health centres.

*“How the message is interpreted can encourage or discourage the uptake of PrEP. More effort should be put to come up with Information Education Communication Materials on PrEP that are written in local languages so that we create rich information base in the community ... this will also reduce the current stigma that exist in the society ... sex education is very important and it is high time PrEP debate to feature prominently in sex education talks in schools, churches etc.”*  
(Key Informant A)

Young urban women fear stigma when visiting clinics to seek information on PrEP, which means that the network depends on a few of their members to pass on the information. The stigma is more prevalent in Kampala; in Kisumu, young women reported increased visits to health facilities for PrEP information.

In both Kenya and Uganda, radio, television and newspaper platforms were not the main sources of PrEP information. Health facilities and personal networks were regarded as the main sources of PrEP information, and hence acted as a rich medium for PrEP information, while radio, television and newspapers acted as a lean medium for communicating routine activities, which is contrary to the power of mass communication channels.

### **How Access to PrEP Information Influences Actions**

*How does PrEP information influence the actions of young urban women?*

In both Kampala and Kisumu, the study participants posited that they are more receptive to information on PrEP when the information passed on by those within their networks and health workers, since there is an element of trust from information sources, unlike when transmitted through radio, television and newspapers, since they believe that these types of media are just in business and broadcast the messages because the broadcast airtime has been paid.

Study participants said that they shared PrEP information discreetly for fear of being accused of having multiple sex partners. Information on PrEP, particularly its efficacy in reducing the risk of contracting HIV/AIDS, has led to a change in attitude, and belief in the HIV/AIDS biomedical prevention method amongst young urban women is therefore increasing in its uptake. However, the study ascertained that young urban women who have multiple sex partners were more aware of PrEP because they frequently visit health facilities. It was also established that there is a high likelihood that those with multiple sex partners have deeper social and peer-based networks, hence act as spreaders of PrEP information. The prevalence of PrEP awareness was also higher amongst non-condom users.

*“I only talk about PrEP with my trusted friends, because any time people hear PrEP they think of you as having several multiple sex partners. I also discreetly visit the clinics especially when I am sure there are few people at the health facility”.* (KU1 – Kampala, Uganda)

*“We talk about PrEP when we go for women group meetings. This is because if you discuss with your husband he might think you have several partners. While it is them – men – who have more sex partners. So any of us in the group who doubts the health status of the husband is always encouraged to discreetly take PrEP ... yes my husband doesn’t know I use it but I do because I know he has many sex partners”.* (KU2 – Kampala, Uganda)

*“It is true that most young urban women who have multiple sex partners are the ones who frequently visit health facilities for PrEP services ... in fact I am one of them and other women rely on us for PrEP information ... such as how it works ... reaction with the body ... because they fear visiting health centres to seek advice on PrEP”.* (KK1 – Kisumu, Kenya)

*“Me I don’t understand what is written in PrEP posters, because they are either in English / Kiswahili and me I don’t understand the languages. They should translate to us in Luo language. When we go for our weekly Merry Go Round, then my friends who understand English / Kiswahili always do help me to*

*understand the information in the flyers ... it is difficult to talk about PrEP in the house, even in church people don't want to talk about PrEP because of fear for being labelled a prostitute ... even going with the flyers to the house is difficult, I have to hide them ... I have a daughter who should know about PrEP but I fear to talk about it with her because it will be seen as I am encouraging her to have unprotected sex which can lead to pregnancy". (KK 2- Kisumu, Kenya)*

It was revealed that while a positive attitude towards PrEP use is steadily building, there is fear of the drug being misused by some reckless young urban women who might take advantage to have unprotected sex with multiple partners. This might reverse gains so far achieved in reducing new HIV infections amongst young urban women.

Another challenge is that as the number of women using PrEP increases, a high lapse rate might occur. This inconsistency in use might compromise its efficacy.

*"Yes I use PrEP, but sometimes I forget or just get tired of swallowing it. I used it for only 2 days then I got tired ... though when I go to our Merry Go Round then I hear my friends talk about their continuous use of PrEP, this encourages me to continue with it again". (KK3 - Kisumu, Kenya)*

## Discussion

In accordance with the precepts of the health belief model, communication on PrEP in the study areas indeed occurs mostly through personal networks and from health facilities, and this influences young urban women's attitudes and beliefs towards PrEP acceptance. The perceived benefits of PrEP in reducing the risk of HIV infection helps young urban women in choosing positive health behaviour.

Young urban women who frequently visit health facilities for PrEP services act as gatekeepers and opinion leaders of PrEP information within their peer-based networks, which are mostly women with multiple sex partners; they infiltrate the complex

interpersonal relations in their circle of friends and families to communicate PrEP information. Success of information flow was attributed to strong interpersonal communication within the networks. In Uganda and Kenya, media outlets, radio, television and newspaper are not the main sources of PrEP information for young urban women but rather act as agents reinforcing the PrEP information already circulating within the interpersonal networks. This evidence supports the tenets of the two-step flow theory. Radio, television and newspapers should improve their messaging on PrEP and contextualise the content in local languages so as to simplify information to the audience; this will further help to reinforce interpersonal communication on PrEP.

## Conclusion

This chapter investigated the attitudes of young urban women as part of the population at risk of contracting HIV. However, there are other sectors of the population at risk: adolescent girls, commercial sex workers, and men who have sex with men. These sectors should be studied too. The study also concentrated on the urban population, while rural areas also experience the burden of HIV/AIDS. The study found that peer-based networks supported by strong interpersonal communication that happens in the networks has proved to be a rich source of information on PrEP. However, how the information is interpreted can likely encourage or discourage uptake. Simpler messaging on PrEP translated into local languages should be produced to fill the misinformation and disinformation gap that exists. There is a high level of stigma surrounding PrEP; hence rich information should be created by the media to step up their messaging on PrEP in order to curb the current stigmatisation.

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## Chapter 9

# The Need for Effective Health Communication Systems in Lesotho

Rethabile Malibo 

### Abstract

Health communication is critical in managing public health concerns and emergencies. The human Coronavirus disease 2019 (COVID-19) outbreak emerged as one of the most significant health crises in the 21<sup>st</sup> century, overwhelming health systems in both developed and developing nations. Lesotho, a developing nation, was not immune to resultant socio-economic and cultural challenges, but what the COVID-19 pandemic highlighted is the importance of having an efficient way of communicating health in managing and mitigating the impact of a crisis. Using articles from newspapers and social media, this chapter explores the critical questions regarding the significance of an efficient health communication system during crises. It adopts four theories of crisis communication to explain the different factors that can influence health communication in Lesotho. In addition, this chapter illustrates that building an effective communication for health encompasses more than just the tenets of communication, as there are other factors outside the realm of communication, such as political will and commitment, public trust, managing public emotions, building competent media systems and stakeholder engagement, all of which must be taken into consideration. Analysing the success and failures of health communication systems employed in Lesotho during the COVID-19 pandemic can yield valuable insights for future public health communication efforts and preparedness during a health emergency.

## Introduction

Health communication is an offshoot of development communication that has spanned several decades and is concerned with communicating information that promotes individual health. Today, health communication has expanded its scope from biomedical interventions at a personal level to more context-based communication about health, which includes the socials and the environment that have impacts on an individual's health (Malikha, 2019). Health communication can take many forms, such as written and verbal, or use of traditional and new media outlets (CDC, 2024) and it is aimed at changing peoples' behaviour to induce action. Effective health communication includes development of materials such as social media posts, brochures, billboards, newspaper articles, television broadcasts, radio commercials, public service announcements, newsletters, videos, digital tools, case studies, group discussions, health fairs, field trips, and workbooks, amongst other media outlets (RHI Hub, 2024). Communicating health has become very imperative as the world is grappling with several health challenges, of which the COVID-19 pandemic was one.

The COVID-19 outbreak in China in November 2019 was characterised by panic and fear as countries grappled with the virus's rapid spread and its impact on public health and economies (Saadat et al., 2020). The uncertainty surrounding the virus, its rapid transmission, and severe health implications fuelled widespread anxiety and apprehension amongst populations worldwide. Governments, health authorities, and individuals were faced with unprecedented challenges, leading to a sense of urgency and concern that permeated all levels of society during the early stages of the pandemic. Some countries, such as Korea, Singapore, and Taiwan, were proactive and responded to the World Health Organization (WHO) call to take aggressive action against the spread of the virus. These countries worked overtime to disseminate information to their constituents about the virus, ways to protect themselves and implemented strict containment measures (Chen et al., 2021). However, this was an exception for Lesotho, particularly considering how pandemic information was communicated.

## Literature Review

### **Contextualising health crisis communication: The case of COVID-19 in Lesotho**

Lesotho was the last country on the African continent to register a COVID-19 case (on 13 May 2020); the announcement came days after questions were raised about Lesotho's COVID-19 testing procedures (Ajansi, 2020). In response to the outbreak, the government of Lesotho created institutions such as the National Emergency Command Centre (NECC) and the National COVID-19 Secretariat (NACOSEC). The objective of these institutions was to coordinate the development and implementation of the country's national COVID-19 strategy and ensure that national resources were used effectively and efficiently. However, the establishments were confronted with their fair share of challenges as the structures and responsibilities needed to be clearly defined, since they were established under a cloud of uncertainty and panic. For instance, it was thought that there was a duplication of efforts between the Ministry of Health and NACOSEC, and it was not clear who of the two was more superior (Public Eye, 2021). Consequently, the Basotho resorted to social media platforms for information.

Social media is one of the most popular digital activities worldwide. In 2022, it was estimated that over four billion people made use of social media, with the most popular platforms being Facebook, followed by Instagram, Twitter (now referred to as X), YouTube and TikTok (Statista, 2024). Social media has a duality of being both an asset and a liability. It is an asset because of its speed, coverage, and penetration; thus, it helps to fill information voids and provide real-time updates. But this very asset is also a liability as it can amplify harmful practices (Corinti et al., 2022; Rathore & Farooq, 2020). The danger of social media lies in its lack of regulation, as anyone with Internet access can post without following editorial policies, journalistic etiquette, or ethical practices (Mukurunge et al., 2020). Information can spread globally and trend rapidly, and when multiple sources share this information, it can be mistaken for factual.

During the COVID-19 pandemic, health officials and governments from other countries used social media as a platform to share information publicly and speedily with their constituents (Pascual-Ferrá et al., 2022), and because of social media accessibility, the Basotho also consumed this information (Mukurunge et al., 2020). However, there was a power struggle between health officials' efforts to disseminate evidence-based scientific information to mitigate the effects of the pandemic and social media influencers or users' theories on COVID-19 (Pascual-Ferrá et al., 2022). This power struggle brought misinformation, myths and conspiracy theories, which caused more panic and anxiety amongst the Basotho (Mukurunge et al., 2020), more so because in the early stages of the pandemic, there was little to no information from the Lesotho government. The information from various sources, including digital media, radio, television, friends and colleagues, was continually changing and often contradictory.

Because individuals became overwhelmed with information, they found it difficult to decipher what was helpful and what was not, making them feel despondent; the feeling of despondency during a pandemic can be dangerous, as it can negatively impact measures put in place to control and manage the virus. Also, the sense of uncertainty can have serious consequences, such as individuals doubting the healthcare system (Naeem et al., 2021). For the Basotho, what was conspicuously missing in Lesotho was a trusted voice to dispel the rumours, provide facts, and present a preparedness plan for dealing with the pandemic. For a long time, this voice was absent. It was clear that an efficient communication strategy was what the country needed.

For effective health communication to take place in a country, especially during a pandemic, the people must trust the government to be able to take action. This chapter looked at how the Lesotho government can gain the trust of the public and at the same time manage their reputation. The point of departure for this chapter is the discussions on Lesotho's health system and COVID-19 response, effective health communication amid crises, and factors that need to be considered to strengthen a health communication system.

## **Gaining public trust and reputational management when health crises occur**

Gaining public trust is foundational to effective communication strategies, especially pertaining to health, where risks can potentially escalate into crises. Rousseau et al. (1998) note that although there is no universally accepted scholarly definition of trust, there is an agreement that trust is an essential factor in several ways, such as enabling cooperative behaviour, promoting adaptive organisational forms (network relations), reducing harmful conflicts, decreasing transactional costs, facilitating the formulation of working groups and fostering effective responses to crises. The government's interpretation and understanding of trust in communication to the public determines its credibility and, ultimately, the public's buy-in. Without trust, the public will not believe any information provided, which can exacerbate or prolong the crisis. Gaining public trust and a good reputation during the COVID-19 pandemic was crucial for ensuring compliance with preventive health measures and vaccination programmes. The incidents that betrayed the Basotho's trust include the theft of a PPE (personal protective equipment) donation from China's Jack Ma and Alibaba Foundation. The donation was stolen from storage no sooner than it arrived in Lesotho. Since the incident occurred, only two people have been arrested, and it is unclear how the case ended. Understanding the factors influencing public trust, such as government effectiveness and accountability, consistent and effective communication, and regulation of media systems, can inform strategies to enhance public trust and promote collective action in response to the pandemic.

For an ideal customer or client to consider an organisation, one of the most critical factors that determine their decisions is the reputation and image of the organisation. Consequently, organisations must invest in reputation management to reach their desired objectives. In the case of governments or public office, their reputation is always associated with negatively charged words such as inefficiency, incompetence, and rigidity (Wæraas & Maor, 2014).

### **Political influence on public trust and reputational management**

Too often, party politics play a significant role in governments, which is a concern when it comes to reputation management (Wæraas & Byrkjeflot, 2012). Political structures and standards inhibit the experts and professionals because their actions, strategies, or proposals may have serious political consequences (Kettl, 2003). In this, Lesotho is no exception, as the government is characterised by one scandal after another. Secondly, party politics always interferes with government structures, such as who should be appointed to what position, sometimes without the right qualifications and skills. When the NECC was disbanded and NACOSEC was established, the new Prime Minister appointed the commissioner-general of Lesotho Revenue Authority (LRA) as the CEO (chief executive officer). While the CEO might have been qualified to perform the job, many questions surrounded his appointment. Chief amongst them was why he occupied two big posts while so many Basotho were unemployed. Other concerns were that it was more of a political move. To allay the Basotho's fears, the public was informed that the CEO would not be paid for his position at NACOSEC but would only receive remuneration for his LRA position. Amid the confusion, a letter of his appointment and benefits was leaked online, thus indicating some inconsistencies about his appointment in the higher offices. In response, the government released a statement apologising to the public for leaking the letter, but the damage was already done. For a newly formed organisation dealing with a pandemic, the negative accounts surrounding a newly appointed CEO were too much baggage to carry.

Reputation management is crucial during crises that might produce adverse reactions amongst citizens and stakeholders. It is imperative that when dealing with a health emergency, health institutions must be able to formulate a persuasive and standard message on how to handle the crisis in a political setting, have high credibility and be able to communicate that message to citizens (Boin et al., 2017; Coombs, 2007). Significant decisions must often be made under extreme time pressures and deep uncertainty regarding the cause of the crisis, how the crisis will develop, and the possible means and measures to mitigate

or resolve the crisis (Ansell et al., 2010). The primary purpose of meaning-making in a crisis is to get others to accept the situation and reduce public and political uncertainty by providing an authoritative account of what is happening, why, and what needs to be done (Boin, et al., 2017). It must frame the unfolding crisis in convincing terms that enhance its efforts to manage it by strengthening confidence in its response. A government's reputation is a multi-dimensional concept, and Carpenter (2010) discusses four dimensions of reputation that can potentially shape the public's reaction and behaviour, namely performative, moral, procedural and technical reputation.

**Performative** is seen as government's ability to carry out a task as it is interpreted as complete and adequate. During the early warning stage, while other countries were turning empty buildings into makeshift hospitals and erecting tents, the NECC and the government had not made any preparations whatsoever. In one session where the NECC was given an assignment to report on its progress, the chairperson said they were still trying to determine how many hospital beds were in the country and which facilities needed to be upgraded. His speech on government preparedness focused more on the approval of documents and legal frameworks and less on actual preparedness, such as buying sanitisers, purchasing more beds for hospitals and procuring more equipment, to mention a few. The inaction of the government and the report left the Basotho feeling dejected with the realisation that more needed to be done.

**Moral reputation** centres on compassion, honesty, and flexibility but, most importantly, ensuring that all activities are in the community's best interest. During the crisis, several corporations and individuals pledged between Lesotho Maloti (M) 25 million (over \$1.3 million) and M30 million to upgrade Lesotho's laboratory system to test for COVID-19 as, at the time, Lesotho relied on South Africa's National Institute for Communicable Diseases (NICD) for testing. Once the equipment was there and the laboratory was set up, the government's responsibility was only to contract a company that would perform the testing. The Minister of Health said on national

television that the government must follow proper procurement channels and will not appoint just one company with a job worth millions of dollars. He also said that the government would only let certain hospitals perform testing to avoid disrupting the statistics. His utterances appeared to cause shock and may have displayed a lack of compassion, as it seemed that the government was worried about due processes only when it suited it to do so.

Secondly, three months after the NECC was established, the centre was associated with a scandal that came to be known as “COVIDgate”. An article published in the *Lesotho Times* newspaper (2020a) reported that the centre had used M161 million of the M698 million budget allocated, with the bulk of the money spent on operational costs such as leasing the Convention Centre where the centre was housed, catering three meals for more than 200 people every day, branding of cars, purchasing of office equipment and other related items at highly inflated prices. For example, the purchase of four 9kg gas cylinders and four heaters cost M184,550, yet these would have cost at most less than M5,000 (*Lesotho Times*, 2020a). All the while, nurses did not have PPE or enough sanitisers. Furthermore, no visible or active campaigning was happening to educate the Basotho on the consequences of the virus even though it was planned for, nor were there any regular updates or dedicated social media platforms from the Command Centre. Moral reputation in the context of Lesotho is parallel with abuse of funds. The abuse of funds during the COVID-19 pandemic has raised concerns about the government’s commitment to its people. Misusing resources or power for private gain sows insecurity and robs the most vulnerable people of desperately needed public services, undermining public trust. Limited trust in the government can hinder the adoption of health and prosocial behaviours, thereby impeding the control of COVID-19 and fostering its spread.

The abuse of public funds during the COVID-19 pandemic shows that the government does not care about its people and is not committed to allocating public resources effectively for the benefit of society. It is essential to combat corruption

and hold the corrupt accountable to promote transparency, strengthen democracy, and ensure the effective allocation of public resources for the benefit of society. By prioritising public trust and accountability, governments can effectively address the challenges of the pandemic and promote overall well-being. The abuse of public funds during the COVID-19 pandemic highlights the need for transparency, accountability, and ethical leadership in government to ensure that public resources are used for the benefit of society.

**Procedural reputation** is more about the government following commonly accepted rules and processes. The establishment of the NECC brought with it several controversies, the greatest of which was its legal standing. The NECC name was changed to NACOSEC and was housed in the Prime Minister's office under the Disaster Management Authority to make it legal, to rebuild, and to restore its image. Because it was established under pressure, several questions still needed to be addressed. For instance, is it autonomous? Can it make its decisions independently and effect them accordingly?

Secondly, there was the appointment of the Chief Executive Officer of the LRA into the office of the newly established NACOSEC. A few weeks after the establishment of NACOSEC, it advertised tenders for the supply of PPE, marketing, advertising and communications consultancy and invited applications for call centre jobs. However, the principal secretary for cabinet administration questioned the move by NACOSEC, stating that it might have overstepped its boundaries by engaging in activities with substantial financial implications without including the government. This only brought more confusion and anger within the public space, and, subsequently, the newly appointed CEO resigned from the job effective immediately. In his resignation press conference, he stated the frustrating conditions under which he had to operate. The *Lesotho Times* newspaper stated that some sources privy to the situation said that he was worried that COVID-19 issues had been politicised and that should he continue working for NACOSEC, his reputation would be tainted (*Lesotho Times*, 2020b). The Basotho, watching all this from the outside and

relying on the government through the designated structures such as the NECC, lost hope because of petty bickering and internal politics that did not consider their lives.

**Technical reputation** is about having the skills and capacities to deal with complex environments. When the NECC was formed, several questions were raised about the skills, qualifications and terms of reference of those employed. There was a demarcation between the technical team or experts and the administrative team. Most announcements were made by the chairperson, the Minister of Communication and Technology, but his voice needed more urgency. At the very beginning, when there was a cloud of anxiety and panic, the voices of health professionals were missing, and this birthed much distrust and impacted the already low reputation of the Command Centre. A notable issue was the lack of expert voices, such as doctors and scientists, at the forefront of public communication during the pandemic.

Effective crisis communication strategies emphasise the need for transparency, civic engagement, and the mobilisation of expertise from various sectors, including government, communities, industry, and academia, especially the health sector. After losing the trust of the Basotho due to the “COVIDgate” exposé in a local newspaper, through relevant structures, the government had to try to rebuild its image and reputation but, most importantly, restore the country’s confidence. This would be done with the realisation that the information and services it broadcasts to the public are well-consumed. To counter the scandals, creating expert communication platforms would have benefited NACOSEC, such as creating a platform where the Basotho doctors or doctors working in Lesotho give medical advice. Throughout the pandemic, the information that the public accessed, from the proper wearing of masks to breathing exercises, was all information circulating online derived from different campaigns run in different countries or from doctors and nurses from other countries. Periodic press conferences were also needed to brief the public on what was happening in hospitals, testing centres, and borders. If this route were taken, it would decrease the Basotho’s desperate need for the Prime

Minister or Minister of Health to give a speech. Since social media became popular, the onus was on NACOSEC to develop a mobile application that could be used to monitor real-time interactions on social media, radio, and television so that organisational bodies could counteract any misinformation even before the narratives exploded online.

The COVID-19 pandemic has underscored the critical importance of trust and reputation management in public health crises. High trust in the government is associated with the adoption of health behaviours and prosocial behaviours during the pandemic. Limited trust in government can hinder measures to combat pandemics like COVID-19. The reputational impact of COVID-19 pandemic management on organisations at the forefront of managing the crisis, such as the WHO, has been significant. The pandemic has adversely affected the reputation of these organisations, highlighting the need for effective reputation management strategies.

Additionally, the value of reputation capital during the COVID-19 crisis has been a subject of study, emphasising the tangible impact of reputation on organisational resilience and stakeholder perception. In light of these, it is evident that reputation management is not a luxury but a business-critical necessity, particularly during exceptional situations such as the COVID-19 pandemic. Building reputation resilience before a crisis is crucial, and effective reputation management should be at the forefront of organisational strategies, as it directly impacts stakeholder engagement and organisational survival.

### **Healthcare challenges in Lesotho using the COVID-19 pandemic as an example**

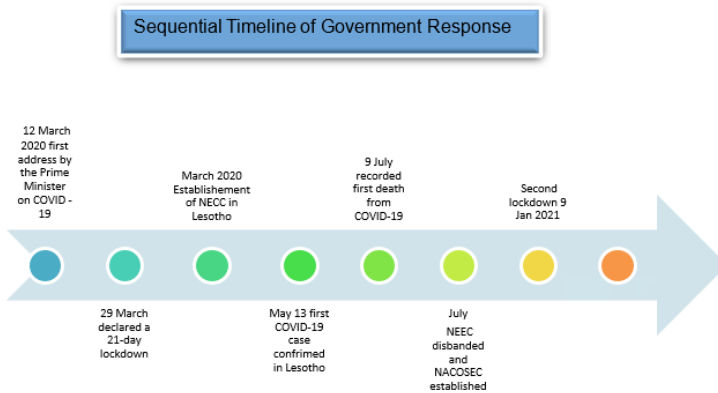
The UN (United Nations) Lesotho report (2021) on the impact of COVID-19 on youth and adolescents refers to Lesotho's health system as 'pressured'. The government, the Christian Health Association of Lesotho (CHAL), and the private sector (non-governmental organisations (NGOs) and private providers) share healthcare services. There are 265 nurse-led primary healthcare centres, most of which are community-based clinics, 20

secondary general hospitals and one tertiary or referral hospital stationed in Maseru (the capital city). The secondary hospitals in Lesotho have a combined bed capacity of 1,833, but the occupancy rate is only 32% (World Bank, 2018), while the tertiary hospital has a 425-bed capacity. The number of intensive care unit beds across the country is 38, with most of the beds found at the tertiary hospital (WHO, 2023). Severe emergency cases of patients who require high-level care are often referred to Universitas and Pelonomi hospitals in South Africa at the expense of the government (UNICEF, 2017).

The healthcare challenges in Lesotho are multifaceted, as access to health remains challenging for most Basotho, particularly those in rural areas, who walk long distances to hospitals and sometimes wait in hospital queues before they are attended to (Mwase et al., 2010). Apart from access, other factors that have a bearing on the country's health system include:

- **Human resource shortages:** - There is a severe shortage of doctors and nurses in Lesotho; there are 20.73 doctors, nurses and midwives per 10,000 people (Asamani et al., 2022) or 0.09 doctors per 10,000 Basotho (World Bank, 2018). This indicates a scarcity of skills in the medical and allied professions, which has led to challenges in managing patients effectively and providing adequate care.
- **Healthcare financing:** - More than 10% of the national budget is allocated to health. However, the country's central hospital consumes more than half of the public expenditure (Ndayizigiye et al., 2022).
- **High disease burden:** - Lesotho has high rates of infant mortality, maternal mortality, HIV/AIDS prevalence and child malnutrition (UNICEF, 2017), which weakens the health system and puts a strain on resources.
- **Inadequate equipment:** - For instance, hospitals only having the capacity to provide oxygen to a limited number of patients simultaneously (Sanders et al., 2021; Webster, 2015).
- **Procurement process:** - There are often delays in processing payments, which results in stock-outs of drugs and medical supplies in clinics and hospitals (UNICEF, 2017).

Based on these challenges, the WHO categorised Lesotho as a high-risk and high-vulnerability country. Given Lesotho’s fragile health system, it was imperative that the government take significant measures to prevent and protect the Basotho against COVID-19. Before the registration of the first case, the government had already declared a national emergency and imposed two compulsory lockdowns on all non-essential services. The first lockdown commenced on 29 March and was initially scheduled to end on 21 April but was extended to 5 May 2020. The second lockdown in 2021 was in response to the increasing mortality rate resulting from COVID-19 infections; it was in effect from 6 January to 20 January and was extended to end on 3 February 2021.



**Figure 1:** Sequential timeline of the Lesotho governments’ response

The government’s response to crises is of paramount importance, as it directly influences the general public’s reaction, mainly because in a crisis, people take in information, process it and act on it differently than they would during non-crises times (Covello et al., 2001; Glik, 2007). Despite the government’s acknowledgement of the prevailing global situation, its response came late and needed more urgency. The Ministry of Health in Lesotho did little to calm the nation through, for instance, allaying public fears by making official statements. The Prime Minister

only gave his first speech regarding COVID-19 on 12 March 2020, addressing only two points: the first was that the government was deeply concerned about the proliferation of COVID-19 and was closely monitoring the situation. The second was that after careful deliberation, the government had decided not to evacuate Basotho nationals in China and had initiated measures to communicate with these citizens through Lesotho's embassy (Government of Lesotho, 2020).

A week later, on 18 March, the Minister of Health and the Prime Minister gave speeches separately. The Minister of Health announced that the situation in Lesotho was under control as a practical response and preparedness strategy had been designed and would soon be implemented; he also assured the nation that schools would remain open and concluded by urging the Basotho to seek health services at a government hospital as the personnel had been trained in handling COVID-19 incidents. A few hours later, on the same day, the Prime Minister went on national television and declared COVID-19 a national emergency; he appealed to the nation to treat the situation with the seriousness it deserves. As a response strategy, the Prime Minister announced the establishment of the NECC, whose sole purpose would be coordinating the country's efforts against COVID-19 as discussed earlier (Government of Lesotho, 2020).

The NECC comprised more than two hundred members, including principal secretaries, directors general, ministers of relevant ministries, development partners, civil society representatives, and non-government organisations. The Minister of Communication Science and Technology served as the Chairperson. The NECC's approach was to design and implement a preparedness plan and containment measures for the pandemic and then later address the economic and social impact (World Bank, 2020).

A few months after its formation, the NECC was dismantled and replaced with the newly constituted NACOSEC. The disbanding of the NECC was a decision by the newly appointed Prime Minister, Dr Moeketsi Majoro. While the Basotho were grappling with the harsh realities brought about by the pandemic, the

government was dealing with internal conflicts erupting from the party with the majority seats, which resulted in a parliamentary vote of no confidence and, ultimately, the dissolution of the coalition government led by Thomas Thabane of the ABC political party. A member of the same party, Dr Moeketsi Majoro, assumed the position of Prime Minister. One of the first things he did was dissolve the NECC and establish the NACOSEC, guided by the provisions of the Disaster Management Act. The NACOSEC was housed in the Prime Minister's office and reported directly to him. The mandate of the Secretariat was parallel to that of the NECC to coordinate and implement all COVID-19 response strategies and measures. In line with its mandate, the NACOSEC developed a five-tier colour-coded risk assessment and mitigation framework to reflect the varying degrees of COVID-19 transmission rates (NACOSEC, 2020).

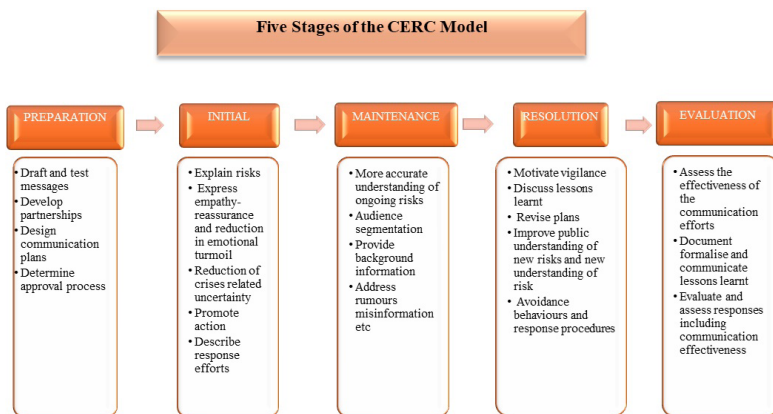
One of the primary challenges highlighted by the COVID-19 pandemic in Lesotho is the need for competent health communication systems, particularly in emergencies. Health communication in African countries, Lesotho included, is already challenging under normal circumstances, as health communication strategies lack coherence and are undervalued and underfunded (Mukurunge et al., 2021; Uwah, 2013; Olaoye & Onyenankeya, 2023). The lack of health communication systems poses a critical challenge that hinders the optimal delivery of healthcare services, threatens public well-being, and diminishes the effectiveness of healthcare initiatives and interventions. This leads to difficulties in managing health emergencies and ensuring public health safety. Lesotho was the last African country to register a COVID-19 case, on 13 May 2020. The country's delayed and, to some extent, uncoordinated response to the pandemic led to many challenges, especially regarding communication. This led the Basotho to rely on information from external sources, both verified and unverified, inadvertently contributing to the spread of the pandemic and impeding them from adopting preventive measures and vaccinations.

## Theories

### Crisis communication theories

Crisis communication theories were used as the theoretical framework for this study as they are crucial in designing effective health communication strategies during health emergencies. The theories discussed here are the crisis and emergency risk communication (CERC) model, the high-risk model of threat perception and the risk information and processing model. These provide a foundation for understanding and influencing health-related behaviours and beliefs and addressing communication challenges.

The CERC model developed by the US Centers for Disease Control and Prevention (CDC, 2018) is a valuable tool for building effective health communication systems during health emergencies, as it provides a structured approach to crisis and risk communication, enabling experts to deliver timely and accurate information to the public, thereby promoting informed decision-making and enhancing overall community well-being. The CERC model consists of five stages: preparation, initial, maintenance, resolution, and evaluation, as illustrated in Figure 2.



**Figure 2:** Five stages of the CERC model (Source: CDC, 2018 )

During the preparation phase, communicators design and pre-test messages, develop partnerships and design communication plans.

The initial phase involves expressing empathy, explaining risks, and promoting action. In the maintenance phase, communicators provide updates and address misinformation. The resolution phase focuses on providing information about the outcomes of the crisis, and the evaluation phase assesses the effectiveness of the communication efforts. An effective CERC ensures that relevant stakeholders communicate to provide timely, accurate, and coordinated information during emergencies. CERC is driven by six principles: Be first, Be right, Be credible, Express empathy, Promote action, and Show respect. These principles allow stakeholders to communicate the right message promptly and in a way that people understand and can act upon in a crisis (Palenchar, 2008).

The high-risk model of threat perception (Wickramasekara, 1979,1986; Griffin et al., 1999) and the risk information and processing model focus on the role of perceived threat in motivating people towards preventive behaviours. The model suggests that higher perceived threats will be associated with higher engagement in self-protective behaviours. Studies on previous infectious disease outbreaks such as SARS (severe acute respiratory syndrome), swine flu (H1N1), and MERS (Middle East respiratory syndrome) show a direct association between perceived threat and adherence to mitigating measures. The high-risk model also highlights the importance of emotional reactions, such as worry, in shaping threat perception; negative emotions make individuals believe that they have control over a situation by seeking out knowledge about a threat. These theories can help in informing the formulation of an effective health communication model that can facilitate the dissemination of timely and accurate information and responses in dire situations such as outbreaks of pandemics.

## Discussion

### **Effective health communication amid crises**

During a public health crisis, effective health communication is not limited to messaging but includes interactions or exchanges of

information and sentiments amongst individuals, communities, and institutions. This type of communication encompasses multiple clear and concise messages about the nature of risk and other messages, not strictly about risk, that express concerns, opinions, or reactions to risk messages or to legal and institutional arrangements for risk management (Powell & Chapman, 2016). Effective communication relies on various external factors beyond the scope of communication, such as political will and commitment, acknowledgement of basic human needs and management of their emotions, building responsive media systems, and stakeholder engagement; all must be considered to strengthen a communication health system that can reach and engage the Basotho, ultimately improving health outcomes and their well-being.

Health communication is pivotal in preventing and managing disease outbreaks. If executed timeously, lives can be saved. It advocates that prevention is better than cure and that individuals should be armed with life-saving information that will lead to adopting healthy behaviours. Several factors influence the adoption of healthy behaviours, such as how individuals acquire, process and absorb information, the socio-economic environment, psychological factors, and media literacy. Changing behaviour is a gradual, inherently unbalanced and context-specific process. It requires constant and consistent messaging to remind individuals of the benefits. The principles of behavioural change emphasise the need for clear messaging to help the targeted audience to understand the risks they face so that they can adopt healthy behaviours that reduce these risks.

The status of the healthcare system in Lesotho necessitates a shift towards investing in prevention strategies instead of treatment, since the vast majority of factors can be addressed before they manifest as health problems. Particular attention must be paid to the Basotho, who mostly reside in rural areas where access to healthcare services, lack of facilities and resources and inaccessible roads are significant issues. One of the ways to invest in prevention is to build and strengthen health communication systems that will provide awareness and knowledge to the population.

An effective health communication system during a crisis requires integrating risk and crisis communication components. Both are essential during crises as they enable individuals and communities to make informed decisions and take appropriate actions to safeguard their health and well-being. Inadequate communication of health risks can escalate into a crisis, with debilitating consequences, including loss of life. The repercussions of inefficient communication in the healthcare setting can be dire, as evidenced by cases where poor communication by healthcare professionals has led to life-threatening complications (Tiwary et al., 2019). Below, we discuss the repercussions of inefficient communication and external determinants that should be considered in designing an effective communication system using documents, newspaper articles and features, audio recordings, WhatsApp clips, video footage, digital media and social media posts from June 2020 to July 2021.

### **Factors that interface with building an efficient health communication strategy**

#### *Effective media system*

The extent of the public's response to a new health issue is determined by how it is introduced into media discourse. Media plays a significant role in shaping the public's perspective on socio-cultural and economic issues. Various traditional and new media platforms were employed during the pandemic to keep the public updated. In an instant, the world transformed into a tightly interconnected global community, and international news quickly became national and local news, especially in the context of Lesotho.

The media industry in Lesotho is still at a rudimentary stage, subscribing to both the traditional (radio, television, and print) and new media (digital media) formats. Lesotho has a single state-owned television station that broadcasts from 6 am to 10 pm and two state-owned radio stations that provide countrywide coverage. In addition, there are thirteen privately owned radio stations, six community radio stations, and five church-owned radio stations, all of which have limited reach. In terms of print,

there are ten private and one state-owned newspapers. More than 70% of journalists do not possess formal training in the media discipline; hence, their reporting lacks critical inquiry and depth. An effective media system must be transparent to build communication and trust, which was crucial for maintaining loyalty throughout the pandemic and ensuring that the public was confident in the information provided. Because of the calibre of journalists, most Basotho relied on international platforms such as BBC, CNN, and Sky News for news updates.

An inherent drawback of accessing international news is individuals' desire to post their interpretation of what was said. Often, their interpretation lacked facts and focused only on negative sentiments, which provided an ideal environment for unfounded false narratives that were embraced and spread by some Basotho, cultivating more panic and anxiety. Some journalists reposted and shared the most controversial posts without interrogating them, mostly because they wanted to be the first to post breaking news so that they could gain more followers.

### *Social media as sources of health-related news*

In a crisis, there is a thirst for new knowledge or information, and in the case of COVID-19, the desire to acquire further information did not align with the pace at which it was coming in. Consequently, people turned to social media despite knowing that some platforms lacked objectivity and accuracy and only focused on negative narratives. The high-risk model of threat perception (Wickramasekara, 1995) and the risk information and processing model (Griffin et al., 1999) aver that negative emotions lead individuals to believe that they have control over a situation by actively seeking information about a threat. For example, an individual preparing for a medical procedure may seek information regarding examination procedures, expected timelines, and outcomes but primarily focuses on potential complications as a coping strategy (Shoemaker, 1996). This desire elucidates why individuals were drawn to negative news narratives about the pandemic. Thus, the media needed to work together to counteract the influence of negativity.

The pandemic led to a shift in communication patterns: the Basotho relied on digital platforms, mainly social media, for information. As mentioned earlier, social media is both an asset and a barrier. During the pandemic, experts deployed it in responding to the crisis by increasing awareness of urgent merging issues and providing actions that the public can take to mitigate the risk. For example, through a WhatsApp audio clip, a doctor alerted the public that hospitals had reached maximum capacity and urged the Basotho to comply with the implemented safety measures. The doctor also advised against the excessive use of indigenous plants, highlighting that although they might aid in combatting COVID-19, they could potentially inflict harm on other organs, such as kidneys, as they have not been scientifically tested. She asked the Basotho to exercise caution, for instance having two tablespoons or a cup of the concoction a day instead of drinking a litre or several litres per day.

The downside of social media is that because of its speed, it can rapidly disseminate false information, leading to an infodemic. An infodemic poses as much, if not more, of a threat than the health issue itself. During the escalation stage, there were accounts that the Basotho were left to die in the facilities that the government identified to deal with the COVID-19 cases. Consequently, most Basotho opted to provide self-care within their households. Due to variations in individual cases, some patients were able to recuperate while others deteriorated and sought medical attention only after the infection became severe, resulting in fatalities.

### **Cultivating resilient media systems during health crises**

Given the above accounts, in order to build a resilient media system, the traditional media should adapt to changes by investing in digital infrastructure to expand their reach on online platforms or social networking sites. They should build strong digital infrastructures to counteract misinformation that could lead to disaster. In that same vein, the factors that make social media an asset also make it a barrier to realising effective communication strategies and responses, as it can disseminate false information, leading to an infodemic. Based on the above,

the media should adapt to changes. It is clear that during the COVID-19 crisis in Lesotho, social media platforms were partially used due to the inability of health communicators and journalists to share experiences and information effectively. The non-employment of social media by verified journalists hindered efforts to enhance public understanding, attitudes, and practices regarding the outbreak and address issues related to fake news and misuse of these platforms.

In an uncertain environment with deadly undertones precipitated by a lack of information or difficulty comprehending a complex health situation, as with the COVID-19 pandemic, the public stays susceptible and consumes any information in the public domain. Accordingly, it was easy for the Basotho to rely on social media or social networking applications as 'new information' was coming in at a reasonable rate despite it not being verified, as opposed to relying on traditional channels whose breaking news segments were often replayed throughout the day, leaving those watching wanting more. While social media seemed a go-to for desperate individuals, most information, for example, symptomatic and asymptomatic transmission rates and virus mutation, was contradictory, mainly because those who had more followers on social media diluted the facts and because there was no media to interrogate and dissect what they were posting versus what the experts said, which caused more panic.

### **Possible risks of health information overload**

Information overload often overwhelms the public and reduces its perception of the urgency and control regarding risk and mitigation. In this regard, the media should proactively shape and guide public discussions on pandemics by using the same media platforms that spread misinformation. This can be done by providing links to trusted healthcare providers and public sources that offer reliable information, thereby dispelling negative narratives. Moreover, this could easily be carried out if Lesotho had a defined and structured framework to communicate crises; the communication framework could include specific guidelines on addressing the epidemiology and pathology of the pandemic, as well as strategies for surveying, managing, and monitoring

the disease during its initial outbreak until the crisis control stage. This framework would provide clear directives for how media organisations should communicate and distribute reliable information during the pandemic.

Furthermore, Lesotho needs to find the means to regulate social media platforms through real-time software, as it is clear that one of the challenges of disseminating credible and dependable information about COVID-19 was due to the need for an effective regulated system on social media platforms. The system could have assisted in countering false narratives about COVID-19 and the ability to provide information that adhered to the necessary standards and ethical principles for reporting disease outbreaks. By addressing these challenges, media organisations in Lesotho can build more effective and resilient media systems to serve the Basotho during health emergencies.

#### *Health communication campaigns*

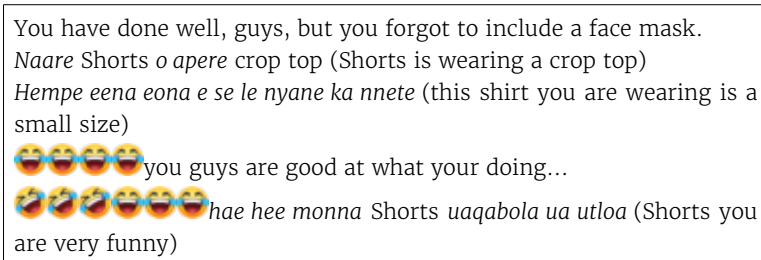
In Lesotho, public health campaigns are very uncommon; very few organisations employ them. This situation can be due to a need for more capacity in health institutions or those who run the programmes need to fully comprehend the employment of public health communication strategies. Furthermore, the few strategies employed are unclear; implementation is rushed, improvised, and sometimes misappropriated or truncated by bureaucratic red tape and ineptness. One of the response strategies that was to be implemented by the NECC was the development of IEC (independent electoral commission) materials and products targeting behaviour change. Several activities were carried out, including billboard posters, branding of cars, one radio spot broadcast on various radio stations in Lesotho, one TV spot and a three-minute TV series consisting of eight episodes, broadcast on Lesotho National Broadcasting Services (LNBS) and later posted on *Lilaphalapha* (production company) Facebook page. The TV and radio spots carried early warning messages running throughout the different phases of COVID-19, from the early warning stage to crisis escalation and effective control stage. Both infomercials were never altered and kept running as they were, even during the introduction of the COVID-19 vaccine.

The three-minute episodes were exclusively aired on LNBS, and despite social media's growing use, no consideration was given to employing it. The decision to broadcast the episodes on LNBS was not well-informed as it is not a popular channel in terms of reach, especially in the rural areas, and its programming in the urban areas competes with international programmes on digital satellite television (DStv). The most popular mode in Lesotho would have been radio Lesotho, as it has a broad reach, especially in rural areas, and the NECC could have taken advantage of that and commissioned a radio series instead.

Regarding the three-minute TV series, the messages were inconsistent and lacked clarity. The series was more entertainment than education and needed to balance aspects of education and entertainment. For example, in episode two, which focuses on lockdown, one of the characters is seen running away from the soldiers on his way to see his girlfriend. He then takes refuge at his friend's house. His friend tells him the lockdown is not meant for security forces, but their role is to ensure that citizens abide by the rules. The episode failed to communicate the importance of lockdown and individuals' responsibility to protect their loved ones by following the rules. The conversation was abstract, and while both washed their hands, they did not wear masks nor mention them in their conversation. The messages lacked clarity. Edutainment is a blend of education and entertainment, which involves strategically incorporating educational content in a way that is entertaining to capture the audience's attention. This could include using songs, dance, TV and radio drama to inform and educate about health, social or economic issues, with the ultimate goal of influencing a change in attitude or behaviour towards the issue (Ngigi, 2018). However, a closer look at the episode shows that the entertainment aspects overshadowed the educational elements, thus failing to achieve the intended objective.

Campaigns designed during a crisis should meet the social and behavioural change principles, as there is a likelihood that if they are excluded, the campaigns can communicate unintended messages or no message at all. For instance, the majority of the reactions on Facebook for this episode were mostly about the costumes of one of the characters called Shorts, or complimenting

the actors on their performance. Some of the comments pointed out that the episode did not highlight important messages, as seen in Figure 3.



**Figure 3:** Reactions to Lilaphalapha Facebook

During a crisis, designing campaigns that do not meet social and behavioural change principles can have unintended consequences. The danger of such campaigns is that they can send mixed or unintended messages, leading to confusion and mistrust amongst the public. Effective communication during a public health crisis is not merely about providing information; it is an interactive process of exchange of information and opinion amongst individuals, groups, and institutions; thus, they need to have a participatory element in them. It is essential to ensure that communication strategies are designed based on social and behavioural change principles to avoid unintended messages.

### **Emotions and community engagement**

The CERC model encourages communicators to express empathy and be mindful of people's emotional turmoil, and this should be considered when designing communication systems. Addressing emotions and community engagement during the COVID-19 pandemic is crucial for maintaining the mental health and well-being of the individual and, by extension, the community. The disparity in information distribution between the NACOSEC and the Basotho during the COVID-19 pandemic resulted in a pervasive sense of fear and panic, affecting people's mental and emotional health. It was a challenge for the Basotho to access Lesotho media platforms and gain sufficient and accurate information

about protecting themselves. The mental well-being of the Basotho, particularly children and adolescents, was impacted during the pandemic (UN Lesotho, 2021). This led to increased anxiety, depression, and distress, which is a common occurrence during pandemics (Veil et al., 2008). Health communication, like all forms of communication, is a bilateral process. It is crucial to recognise that, in addition to dealing with a physical health crisis, people's emotional well-being is also impacted and needs to be addressed. Therefore, in dealing with a physical health crisis, it is imperative to attend to the cultivation of emotions as they take a toll on an individual's mental health. Emotions play a significant role in determining whether individuals will accept or reject a concept. In dealing with COVID-19, the emotional aspect of dealing with the pandemic in Lesotho was not recognised; hence, there were little to no interventions to address it. For example, radio call-in programmes and interactive applications to assess and assist individuals' emotional state would have been helpful, as was the case in other countries like Zimbabwe with the 'Friendship Bench', where trained health workers provide free counselling through WhatsApp (Chibanda et al. 2015). In Lesotho, however, the NACOSEC and the government prioritised other matters unrelated to mental health.

It is essential that when designing communication systems, the aspects of emotions should be considered, as emotions influence audience reactions and are crucial in tailoring messages that resonate with individuals and motivate behaviour change (Myrick, 2015). However, caution should be exercised when appealing to emotions to avoid unintended consequences. Therefore, factors such as the intensity of the message, individual differences, and the core relational theme of the target emotions should be considered to avoid adverse outcomes (Nabi, 2015).

The CERC model also encourages community engagement. Engaging the community in health communication involves developing relationships that enable stakeholders to collaborate in addressing health-related issues and promoting well-being to achieve positive health impacts and outcomes. This process allows for changes in behaviour, environments and practices within communities, emphasising the importance of involving

community members directly in decision-making processes and implementation of health interventions. Before COVID-19, funerals would often last the whole day, but during the pandemic, funerals were identified as super-spreader events. To prevent further spread, it was mandated that funerals should not exceed two hours. Through community engagement, the communities, together with their leaders, such as local chiefs and religious leaders, played a crucial role in ensuring compliance with the regulations because they have ownership of the issues and are accountable to each other. Community engagement in health communication is crucial for empowering communities, fostering trust, and ensuring that interventions are tailored to the specific needs of diverse populations. Therefore, government should adopt a community-driven approach to enhance the effectiveness and sustainability of health communication efforts. In Lesotho, the government just needs to strengthen this aspect by including other segments of the population.

The scope of community participation and emotional engagement extends beyond the duration of the pandemic and includes the residual consequences after the health crises have subsided. For instance, in a bid to flatten the curve<sup>1</sup>, all institutions of learning were closed. However, this led to another challenge, which bore truth to the adage that an idle mind is the devil's workshop. The incidence of adolescent pregnancy and substance and alcohol abuse indisputably surged, resulting in yet another health crisis. Appropriately interacting with the community is essential to foster their involvement from the beginning so that they have ownership over the issues and are accountable. Community participation can be enhanced by assuring the inclusion of diverse population segments. Furthermore, since community participation involves interacting with individuals, it is essential to acknowledge and address their emotional requirements, acknowledge their fears openly and provide accurate information that can alleviate anxiety and stress.

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1 'Flattening the curve' - Employing public health strategies to slow the spread of COVID-19 so that the peak number of people requiring care at one time is reduced in order to prevent the healthcare systems from being overwhelmed.

Governments can better cope with the challenges by prioritising emotional support and encouraging community participation.

### **Misinformation and myths**

The lack of easily accessible information during a disease outbreak leads to the spread of myths, misconceptions, misinformation, and disinformation, sometimes called an infodemic. In fact, Nyandoro et al. (2024) note that prior to the appearance of COVID-19 the WHO Director-General raised concerns that the outbreak was already accompanied by an infodemic. Many Basotho on social media have propagated misinformation and conspiracy theories about the pandemic, which has inundated Lesotho with misinformation and disinformation. In 2021, Lesotho had 530,000 social media users (datareportal.com, 2021), with Facebook registering the highest number of users, followed by YouTube, Twitter, Pinterest, Instagram and Tumblr, as illustrated in Figure 4.



**Figure 4:** Lesotho social media statistics (Source: datareportal.com, 2021)

The use of social media and cell phone messaging to address health emergencies is not new. They have been utilised for information dissemination during outbreaks. For example, Twitter and SMS (short message service) messaging were used in Nigeria during the Ebola outbreak to provide accurate information and to combat misinformation (Carter, 2014; Kamal-Yanni, 2015; Nwogwugwu, 2022). In Sierra Leone, SMS was used to monitor the Ebola outbreak, and WhatsApp was used to dispel myths and rumours about Ebola and communicate with quarantined individuals (Rubyan-Ling, 2015; Turner et al., 2016). With the rapid transmission of COVID-19, social media became a popular

platform for governments and health officials to update the public with information about the pandemic.

Lesotho has faced recurring issues with misinformation and conspiracy theories about the pandemic. Many inaccuracies have spread through social media, such as the belief that the COVID-19 virus cannot survive in Africa's hot temperatures. Another misconception is that the Basotho's blood is strong due to Lesotho's high elevation, making them resistant to the virus, or that the mandatory BCG (Bacillus Calmette-Guérin) vaccine renders their bodies immune. There were also reported narratives of the Basotho employed as nurses in the UK (United Kingdom) testing negative despite being in contact with people who had tested positive or cases in which a couple, the husband who is South African, tested positive and in contrast, his Mosotho wife tested negative despite sharing a bed and living in the same house. There were also religious conspiracies that COVID-19 is considered malevolent, and individuals can only resort to prayer, as it is believed to signify the apocalyptic period mentioned in the Bible. A WhatsApp video clip was circulating featuring a priest in a church who said that COVID-19 is demonic since it demonstrates mathematical knowledge by spreading exclusively in locations where fifty or more individuals have gathered.

Other conspiracies included:

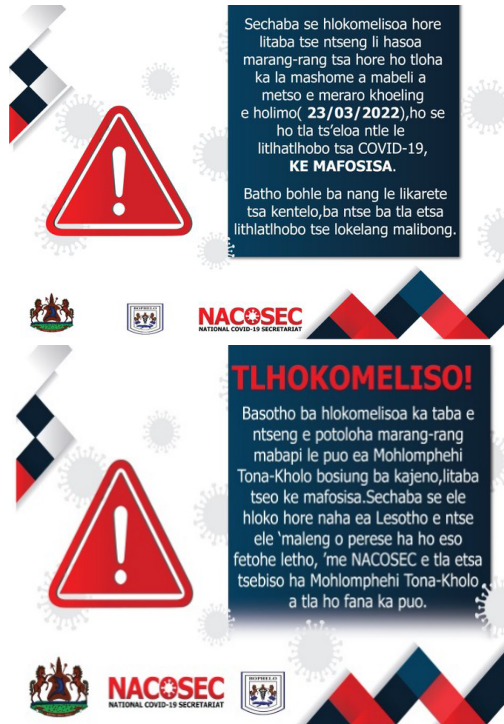
- Gargling with salt water kills the germs and prevents the virus from leaking into the lungs.
- COVID-19 is a disease that attacks animals and not human beings, and the disease cannot attack the Basotho.
- That COVID-19 could be spread by talking on the phone.
- That the virus will not attack priests because they are children of God.
- 5G ('fifth generation') technology is responsible for the pandemic.

The narratives quickly spread across digital media, leading to some Basotho becoming complacent and developing a false sense of security about the pandemic. This has resulted in disregarding preventative measures recommended by public health officials to control and manage the spread. For example, Romer and

Jamieson (2020) argue that individuals highly engaged on social media and networking sites are less likely to wear masks despite health officials' recommendations. In the absence of a clear communication strategy when dealing with health emergencies, myths and misinformation dominate the space and lead the narrative; consequently, government and health officials tend to react to what is already put out instead of the government empowering their constituents with accurate information and leading the narrative as is the case below .



This a letter that was previously circulated supposedly from the Ministry of Health confirming a COVID-19 case.



**Figure 6:** Debunking rumours and myths - posts from the NACOSEC Facebook page dispelling some of the rumours

Information often overwhelms the public and reduces their perception of urgency and control regarding risk and mitigation. In this regard, the communication system should proactively shape and guide public discussions on pandemics by utilising the same media platforms that spread misinformation. For example, fake information online, supposedly from UNICEF (the United Nations Children's Fund), was circulated through WhatsApp and Facebook. However, when UNICEF debunked the rumour, they only used Facebook. They did not create a WhatsApp version, meaning those who received the message via WhatsApp and were not active on Facebook may not have received this information. Therefore, when dispelling rumours, it is important to use all available communication platforms.



**Figure 7:** UNICEF Debunking myths

When debunking myths, accurate information should be substituted; thus, it is crucial to provide links to trusted healthcare providers and reliable public sources. For instance, in the above example, UNICEF informed users that the information did not come from them and provided links to access safety tips. They also mentioned the communication platforms that they use. However, they should have also provided the correct information. Due to the high amount of misinformation on social media in Lesotho, organisations such as the Lesotho Communications Authority (LCA) and the Media Institute of Southern Africa (MISA), Lesotho issued statements advising their licensees and consumers to refrain from sharing false and fake information (Lesotho Communications Authority, 2020). The statements also emphasised that such actions are considered criminal. The LCA shared the statement on its website with an option to share. While this was a step in the right direction, posting the statement on the website limited its reach. To address such incidents, the government of Lesotho and designated institutions must utilise social media platforms to provide comprehensive information. For instance, analysis of the NACOSEC Facebook page, which

has 31,000 followers, and Twitter, which has 6,875 followers, shows that the accounts were not effectively utilised. Most posts consisted of weekly COVID-19 updates with statistics on specimens tested, positive cases, recoveries, and deaths, and sometimes the posts were inconsistent. Engagement rates on both platforms were relatively low.

Crisis communication is highly demanding, and two crucial elements to counter an infodemic are transparency and consistency. It is important to openly and honestly declare what is known and what is unknown and to keep to the facts as much as possible, as advocated by the CERC model. Health officials and governments need to acknowledge if the facts are temporary due to ongoing investigations. The available data should be consistently updated and modified based on new evidence of the disease and its management. Given the rapid changes in a health emergency, it is crucial to provide clear recommendations based on new, previously unknown evidence. Information should be consistent and specific. Even if it is an acknowledgement that much is unknown, it is essential not to get stuck in vagueness, which fuels fear. Lesotho needs to establish a defined and structured framework for communicating during crises. This framework should include specific guidelines for addressing the health crisis epidemiology and pathology, as well as strategies for surveying, managing, and monitoring the disease from its initial outbreak to the crisis control stage. These guidelines will provide clear directives on how health officials, the government, and other stakeholders should use social media to communicate and distribute reliable information during the pandemic.

Furthermore, Lesotho needs to find ways to regulate social media platforms through real-time software. One of the challenges in disseminating credible and dependable information about COVID-19 was the lack of an effective regulated system on social media platforms. Such a system could have countered false narratives about COVID-19 and provided information that adhered to necessary standards and ethical principles for reporting disease outbreaks. The fact that the mainstream media in Lesotho did nothing to refute the falsehoods merely cemented the narratives. Despite the prominence of these articles, both the

press and the NACOSEC failed to take any action to address the matter. The NACOSEC primarily emphasised prohibitions rather than providing sufficient guidance on proactive community actions. In this regard, the government, through the relevant structures, needs to keep ahead of the public to shape and lead narratives on pandemics by using the same media platforms that spread misinformation to dispel negative narratives, for example, by offering links to trusted healthcare providers and public sources providing the same or similar messaging. By addressing these challenges, media organisations in Lesotho can establish more effective and resilient social media systems to serve the Basotho during health emergencies.

### **Conclusion**

COVID-19 has highlighted the importance of an effective health communication system in managing a public health crisis. However, in Lesotho, the system has been ineffective, especially during the beginning stages of the outbreak of COVID-19, which has led to challenges in managing the pandemic and ensuring public safety. The above discussion shows that the point of departure for an effective health communication system must be long before a disease outbreak or pandemic and should continue after the threat has receded. Several factors must be considered to attain an effective health communication system. Some are directly related to communication issues, and others are outside the tenets of communication, but both have the same bearing as they are interconnected. The chief issues that should be considered are political will and commitment, which are essential for creating an environment that enables the management of public health crises and the building of an effective health communication system.

In order to build and strengthen an effective health communication system, the government must be equipped to lead the response in all aspects through its established structures. This means acting accordingly, making sense of the unfolding situation, and comprehending it perfectly. Health issues are delicate, and in the case of a pandemic, there is a need for immediate action from responsible parties to avoid an infodemic;

this means that the government must be decisive and collaborate with all stakeholders, private and public. Furthermore, the government must formulate and communicate a clear and enabling understanding of what should be done to minimise the crisis.

The pandemic evoked a lot of emotions in individuals, the most prominent being fear. Fear can be a powerful motivator for action, but it is essential to balance it with accurate information through a resilient media system and expert voices to avoid panic and misinformation. Government commitment and political will are fundamental to effectively fighting COVID-19 and promoting sustainable development. By prioritising public trust, the public's emotions, transparency, accountability and engaging with stakeholders, governments can build and strengthen communication systems that effectively address the challenges that health emergencies bring and promote overall well-being.

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## Biography

Rethabile Malibo is a Lecturer at the National University of Lesotho English Department, Drama Unit, and a Theatre practitioner. Her work focuses on strengthening the role of applied theatre in effecting personal and socio-economic change in post-colonial spaces. In addition to her role as a lecturer, Rethabile is also a communication for development consultant. She has undertaken consultancies to design and develop communication strategies and produce multimedia knowledge products for public and private organisations in Lesotho.





## Chapter 10

# A Comparative Review of Health Communication Research in West Africa and Other Sub-Saharan African Countries (2018–2022)

Ijeoma Ajaero 

### Abstract

Health communication is a recent field of study, yet it is one of the most rapidly growing and developing subdisciplines within the field of communication. Research about health communication is instrumental in terms of bridging the gap between scientists and practitioners as well as informing health promotion and predicting behavioural and other outcomes. A qualitative approach was employed, to conduct a meta-analysis of four major international health journals over a five-year period focusing on health topics, research methodology, and the theories used in sub-Saharan countries. In total, 125 articles were reviewed. The results indicate that few articles on these subjects were published in sub-Saharan countries over the five-year period. Furthermore, there was a greater concentration of research in some countries than in others. These results are important in terms of informing researchers about countries that have a deficit of research as well as the areas of research that are lacking.

### Introduction

Communication is a core part of health delivery, and governments all over the world continue to develop campaigns and messages aimed at drawing citizen's attention to the importance of maintaining a healthy lifestyle. Recognising its importance

in healthcare, the World Health Organization (WHO) came up with a strategic communications framework for effective communication, with a goal 'to provide information, advice and guidance to decision-makers (key audiences) to prompt action that will protect the health of individuals, families, communities and nations' (WHO, 2023). This strategy is key to WHO's mission of promoting health, keeping the world safe and serving the vulnerable. In addition, the United Nations Sustainable Development Goal 3 (Good health and well-being) (UN, 2023) aims to ensure healthy lives and promote well-being for all. One of the main goals of public health communication is to promote risk-reduction behaviour through health messaging that shapes the public's attitudes and perception of risk (Nan & Thompson, 2020). Public health communication in the sense that it is understood today has required contemporaneous advancement and innovations in the allied disciplines of public health and social sciences as well as in the communication industries (Salmon & Poorisat, 2020).

Health communication is one of the most rapidly growing and developing subdisciplines within the field of communication (Thompson, 2014) – one of the most vibrant, complex and significant areas of research and practice in contemporary society (Harrington, 2015) - and researchers often work across health issues to engage in research that bridges the distance between bench scientists and practitioners (Silk et.al., 2020). It refers to using communication theory, evidence, techniques, and creativity to inform, educate and influence public views and perceptions, and promote behaviours and practices that advance the health and well-being of individuals and communities (Olaoye & Onyenakeya, 2023). Contemporary research on health communication has been marked by the presence of big data and computational social science (CSS) techniques (Rains, 2020), while socio-economic challenges, communicative barriers, and the lack of health infrastructure constitute and reinforce obstacles to health for all, especially for those who live in the underserved spaces of the Global South (Dutta, 2020).

This chapter explores articles published in two health communication journals and two public health journals from

international publishing outfits, over a period of five years (2018 to 2022). The five-year timeframe was purposely chosen to cover the pre- and post-Coronavirus disease 2019 (COVID-19) era in a bid to identify health communication research conducted in sub-Saharan Africa, the nature of collaboration between scholars, theories and method(s) prevalent in the study area. The chapter attempts to critique research in sub-Saharan Africa with a special focus on the West African context.

## Literature Review

### Advent of Health Communication

Some researchers trace back the origins of the study of health communication to the work performed by paediatrician Barbara Korsch and her colleagues in the late 1960s (Thompson et al., 2014). They assessed provider-patient interaction and suggested that the field of health communication might offer a distinct arena for consideration. Consequently, Harrington (2015) submits that health communication officially became a subdiscipline of communication in 1975 at the annual convention of the International Communication Association (ICA). Limage et al. (2014) recount that in the 1980s, the strongest health communication programme in sub-Saharan Africa was focused on routine immunisation, child survival and family planning. Furthermore, in 1986, Lawrence Eribaum publishers produced a journal called *Health Communication*, with early submissions focused almost exclusively on the interpersonal aspects of provider-patient interaction, while subsequent submissions quickly expanded to include health campaign issues (Thompson, 2014). Then, in 1996, a second journal focused on health communication, *The Journal of Health Communication*, was started, and this journal began with more of a social marketing and international focus. Both journals have continued to flourish. Today, there are many journals on public health and other aspects of health that publish health communication-related studies all over the world.

Health communication is central to campaigns that convey health information to communities and facilitate health education and health promotion. It is also central to community participation, empowerment and the building of partnerships grounded in trust and mutual understanding (Olufowote, 2014). In recent decades, gaps in health equity between countries and amongst social groups within countries have widened, irrespective of the progress recorded in medicine and technology (WHO, 2021). The prevalence of health-related calamities, high infant mortality, below-average life expectancy, and the effectiveness of various health communication strategies and/or campaigns are largely understudied in Africa (Fletcher, 2014). With over 890 million inhabitants in 54 countries, the African region accounts for about 12% of the world's population (WHO, 2022). Sub-Saharan Africa has approximately 10% of the world's population, but bears 25% of the world's disease burden, within a context of increased poverty, food insecurity, indebtedness, poor economic performance, gender inequality, gender-based violence, conflicts, natural disasters, ignorance, fear, stigma and discrimination (Limage et al., 2014). Researchers and public health professionals have long realised that the only long-term solution to the region's deadly diseases requires interventions at multiple levels, including changing people's social and physical environments, providing access to care and treatment and ultimately changing people's behaviours (Limage et al., 2014). However, recent studies have shown that during the first decade of the 21<sup>st</sup> century, under-five years of age mortality fell by 35%, neonatal death dropped by 21% and maternal mortality declined by 28% (WHO Africa, 2022), thus supporting Olaoye and Onyenankeya's (2023) observation that health communication in sub-Saharan Africa has proved essential in providing meaningful information and cultivating attitudinal and behavioural change amongst people regarding personal and public health issues.

Like other continents, Africa is grappling with many health-related issues such as COVID-19, Lassa fever, malaria, and HIV/AIDS, and, understandably, communication scholars have conducted several studies in a bid to investigate the effects of health-related campaigns and messages related to these diseases

on the public's attitude to their health, and its implications for policy decisions in Africa.

## **Nature of Health Communication Scholarship**

Health communication is a multifaceted field of research, theory and practice concerned with delivering health-related information to diverse populations (McCulloch et al., 2021). The field is evolving in response to the need to address significant healthcare and policy problems (Hoffman-Longtin et al., 2020). It is uniquely positioned as an effective approach to lowering morbidity and mortality within the region, as it lends itself to be grounded in the socioecological context, including enabling environments, service delivery systems, communities and household dynamics which influences individual behaviour (Limage, et.al., 2014). As scholars whose backgrounds were in other areas of the field saw the potential application of their work in, for instance, persuasion or mass communication, they began to turn their focus to the healthcare context as well (Thompson, 2014).

Multidisciplinarity draws on knowledge from different disciplines but stays within the boundaries of the home disciplines (Choi & Pak, 2006). It involves researchers from multiple disciplines that independently investigate the communication dimension of a health problem (Harrington, 2015). The fundamental focus of multidisciplinary work in the field of health communication is investigating a common health problem by applying concepts from different disciplines to the problem (Cohen, 2022). In an interdisciplinary approach, on the other hand, scholars jointly address a common health problem. It analyses, synthesises and harmonises links between disciplines into a coordinated and coherent whole (Choi & Pak, 2006) as well as connects scholars from different fields who use different approaches to gather data and build evidence-based practice (Cohen, 2022). Scholarship in the field of health communication is broad, with interdisciplinary contributions from researchers trained in a variety of fields, including communication, nursing, medicine, pharmacy, public health and social work (Hoffman-Longtin et al., 2020). It involves researchers from multiple disciplines who collaborate to investigate the multiple dimensions

of either a health problem in general or the communication aspect of a health problem (Harrington, 2015). It is important as it creates room for different people to focus exclusively on different aspects of the same problem.

Transdisciplinarity integrates the natural, social and health sciences in a humanities context, and transcends their traditional boundaries (Choi & Pak, 2006). It is research that spans disciplinary boundaries to create new theories and methods that integrate knowledge from multiple disciplines to address complex social problems (Harrington, 2015). This translational activity is essential to increase the likelihood that emerging science from the laboratory makes it into the hands of health professionals who can integrate it into their everyday practice with patients (Silk et al., 2020) and the promotion of health and well-being (Harrington, 2015). However, Cohen (2022) concludes that evidence of truly transdisciplinary approaches and outcomes from health communication scholarship is rarer in the field.

As health communication scholars continue their work, our knowledge will be enriched through these forms of research, as an integration of theory and practice takes place within the context of multidisciplinary, interdisciplinary and transdisciplinary content, epistemologies and practices (Cohen, 2022).

### **Methodology**

This chapter used a qualitative approach to review four major international health journals (*Journal of Health Communication*, *Health Communication*, *BMC Public Health* and *PLOS Global Public Health*). Journal articles published from 2018 to 2022 were critically reviewed to ascertain health topics, research methodology, theories used and countries. The *Journal of Health Communication* and *Health Communication* are the most prominent journals dedicated to health communication scholarship, thus offering a representation of current trends in health communication research (McCulloch, et.al., 2021; Thompson, 2014). Also, *BMC Public Health* and *PLOS Global Public Health* are leading journals in public health. Articles for this study were assessed on the journals' websites. The study spanned five years

(2018 to 2022), covering the period before and after the COVID-19 pandemic. The research method used was content analysis as articles in the chosen journals that fell within the timeframe were analysed.

The keyword 'Africa' was used to search for articles in the two health communication journals while the keywords 'health communication', 'health messages', and 'health campaigns' were used to search for publications in the two public health journals. For *Health Communication*, the search yielded 398 articles, while the *Journal of Health Communication* had 184 articles within the study period. However, articles on African Americans, black / African Americans, black communities and other parts of Africa were excluded. *BMC Public Health* yielded 1,670 results, while *PLOS Global Public Health* had 1,023 articles. Articles that were not within the study period and concentrated on other parts of Africa were eliminated. Only articles on sub-Saharan Africa were analysed to ascertain the prominent health communication topics in the region, the contribution of research about West Africa and other parts of sub-Saharan Africa, the interdisciplinary nature of publications across the regions and the theories and research methodologies employed. Authors' affiliation was categorised into three: medical (nursing, pharmacy, medicine and other related fields), communication scholars (media studies, mass communication, journalism and other communication related fields) and interdisciplinary (a combination of medical, communication-related fields and the social sciences). Research methodologies was classified under quantitative (surveys, experiments, quantitative content analysis and quasi-experiments); qualitative (in-depth interviews, FGDs (focus group discussions), qualitative content analysis and ethnography); mixed methods (more than one research method used); and reviews (systematic reviews, meta-analysis and other types of reviews).

## Results and discussion

A total of 125 articles on health communication was found from the four journals and analysed. The *Journal of Health Communication* and *Health Communication* each published nine

articles for the five years under review. Of the nine articles, five from *Journal of Health Communication* and five articles from *Health Communication* were published on countries in West Africa - see Table 1.

However, the two public health journals (*BMC Public Health* and *PLOS Global Public Health*) had more articles that addressed health-related issues in the region. The total number of publications in these journals is 107 (*BMC Public Health* [n=79]; *PLOS Global Public Health* [n=28]).

This result is consistent with the studies by Nazione et al. (2013) and McCulloch et al., (2021) on these two health communication journals. For Nazione et al. (2013), Africa, including Madagascar, was the subject in only 8 (2.3%) publications from *Health Communication* and 18 (5.4%) in *Journal of Health Communication* for a period of ten years (2000 to 2009). Similarly, the study of the two journals by McCulloch et al. (2021) found that out of 2,050 articles published in the two journals over a period of ten years, Africa was the focus in only 22 articles in the *Journal of Health Communication*, and in 15 articles in *Health Communication*.

The use of theory for health communication research in the sampled journals was minimal. Only ten out of 125 articles made use of theory. Using content analysis, McCulloch et al. (2021) found that health communication research often lacks a theoretical underpinning. This can be linked to the authors' affiliations, as most studies in the two public health journals are written by those in the medical field, and, accordingly, do not have any theoretical underpinning.

Furthermore, the most common research methodology was quantitative (n=71), followed by qualitative (n=38), mixed methods (n=8) and reviews (n=8); while the sampled publications covered a wide range of health-related topics like polio, COVID-19, hypertension, diabetes, HIV/AIDS, cholera, family planning, sexual and reproductive health, malaria, vaccines, Lassa fever, Ebola, and so on.

**Table 1:** Results from the journals sampled

<b>Journal(s)</b>	<b>Number of articles</b>	<b>Author(s) affiliation</b>	<b>Theory</b>	<b>Research Methodologies</b>
<i>Journal of Health Communication</i>	Nine articles (West Africa, n=5; other parts of sub-Saharan Africa, n=4)	Interdisciplinary (3); medical (4); communication scholars (2)	Protection motivation theory; extended parallel processing model and framing theory; diffusion of innovation and integrated model of behaviour; health literacy skill framework	Quantitative (7); qualitative (2)
<i>Health Communication</i>	Nine articles (West Africa, n=5; other parts of sub-Saharan Africa, n=4)	Communication scholars (7); interdisciplinary (2)	Hybrid sociolinguistic approach (1); culture-centred approach (1); Advertising Research Foundation's hierarchy of effects model (1); framing theory (1)	Quantitative (3); qualitative (3); mixed methods (1); review (2)
<i>BMC Public Health</i>	79 articles (West Africa, n=27; other parts of sub-Saharan Africa, n=52)	Interdisciplinary (32); medical (46); communication scholars (1)	Diffusion of innovations (1); social network theory (1); theory of triadic influence (1)	Review (4); quantitative (44); qualitative (25); mixed method (5)
<i>PLoS Global Public Health</i>	28 articles (West Africa, n=4; other parts of sub-Saharan Africa, n=24)	Medical (12); interdisciplinary (16)	Agenda-setting theory	Qualitative (8); quantitative (17); mixed methods (2); review (2)

### **Health communication research in West Africa**

Table 2 shows the subject matter that dominates research in West Africa, the countries of focus for this research, health topics, author(s) affiliation, theories and research methodologies. It is discouraging to note that health communication research in West Africa is not thriving, with most of it focused on Nigeria, the region's most populous country. For the five-year period under review, only five articles from *Health Communication* and five articles from the *Journal of Health Communication* were on the West African region. For these two important journals dedicated solely to health communication, the topics treated were polio, HIV/AIDS, malaria, sexual and reproductive health and family planning. Nigeria is one of four countries that is still grappling with the polio virus, with challenges encountered mainly in the north (Olufowote, 2014), and the study on polio in Nigeria was centred on the northern part of the country. Studies on the issue of the recent COVID-19 pandemic and the myths and misinformation surrounding COVID-19 vaccines were absent in studies on West Africa in the journals sampled.

There are several media campaigns and messages on COVID-19 by governments in the region, geared towards sensitising the people to the dangers of the virus and the importance of taking the COVID-19 vaccine. According to Olufowote (2014), the health challenges and issues that Nigeria faces include the eradication of polio, infant and maternal health, HIV/AIDS, and media research ethics. Similarly, Senegal fits the health profile of many developing countries, but the nation has gained prominence for its HIV/AIDS prevention success (Ndiaye & Diouf, 2014).

While there was a low number of publications in the two journals of communication, the other two public health journals (*BMC Public Health* and *PLOS Global Public Health*) had the most publications on health communication in Africa. They published articles from the region on polio, malaria, tuberculosis, sexual and reproductive health, and family planning, amongst other topics. McCulloch et al. (2021) came to the same conclusion: health communication scholars study a broad and varied range of topics,

**Table 2:** Health Communication Research in West Africa as represented in the sampled journals

Journal(s)	Country	Health communication topics	Author(s) affiliation	Theory	Research Methodologies
<i>Journal of Health Communication</i>	Nigeria (1); Niger (1); Senegal (1); West Africa (involves countries in West Africa) (2)	Malaria (2), sexual & reproductive health (1), family planning (2)	Interdisciplinary (3); medical (2)	Diffusion of innovations & integrated model of behaviour (1); health literacy skill framework (1); communication infrastructure and discrete emotions theories	Quantitative (3); qualitative (2)
<i>Health Communication</i>	Nigeria (2); Liberia (2); Ghana (1)	Polio (1); HIV/AIDS (1); peacebuilding (2); opioid crisis (1)	Communication scholars (4); interdisciplinary (1)	Culture-centred approach (1); Advertising Research Foundation's hierarchy of effects model (1); framing theory (1)	Quantitative (2); qualitative (1); review (2)

Journal(s)	Country	Health communication topics	Author(s) affiliation	Theory	Research Methodologies
<i>BMC Public Health</i>	Ghana (7); Nigeria (12); Cameroon (2); Benin (2); Burkina Faso (1); Senegal (2)	Adverse drug reaction (1); improved donor relations (1); polio (3); malaria (4); tuberculosis (1); livelihood empowerment (1); anti-smoking (1); health information-seeking behaviour (1); suicide (1); consumption of energy drinks (1); Lassa fever (1); smoking/tobacco (1); disease surveillance and response (1); maternal and neonatal immunisation uptake (1); helmet use (1); immunisation (1); epidemic management (1); sexual and reproductive health (1); tobacco (1); hypertension and diabetes (1); family planning (1); cholera vaccination (1)	Interdisciplinary (8); medical (17); communication scholars (1)	Social network theory (1); theory of triadic influence (1)	Review (1); quantitative (16); qualitative (8); mixed methods (2)
<i>PLoS Global Public Health</i>	Nigeria (1); Ghana (1); Senegal (1); Sierra Leone (1)	Eye health (1); abortion (1); Ebola (1); family planning (1)	Medical (2); interdisciplinary (2)	Agenda-setting theory	Qualitative (2); quantitative (1); mixed methods (1)

thus affording researchers the ability to better address health-related issues that may otherwise be overlooked.

Health campaign research is a very important area of the field of health communication, especially amongst those scholars with a background in communication or public health (Thompson et al., 2014). From the sampled journals, several articles dealt with health campaigns and their influence – for example: “Extending communication campaign from health to peacebuilding: A locally driven communication campaign approach as part of a peacebuilding initiative in Liberia”. Fittingly, the authors were all from the communication discipline, except one who was from marketing. However, *BMC Public Health* had more medical personnel publish health communication articles than communication scholars. Most articles by communication scholars appeared in *Health Communication*, with just one in *BMC Public Health*. The interdisciplinary nature of health communication was evident in scholars from different disciplines publishing articles on health communication messages, campaigns, and behavioural studies.

Furthermore, Thompson et al. (2014) concluded that in recent years two new foci have become pervasive in health communication research: health content in the media and the role of technology in health communication. Publications from West Africa in the sampled journals showed that research in the region, though minimal, is keeping up with the current research trends in the field. Several methodologies have been employed in studying health communication, and these were evident in the publications found in the sampled journals. The research methods used by these authors were:

1. Exploration and descriptive: A number of studies from the region made use of in-depth interviews, focus group discussions, case study, survey and ethnography.
2. Examining interpersonal exchanges and messages: Some studies also made use of content analysis, narrative analysis and social network analysis.
3. Causal explication: A number of were experimental studies.

4. Cultural, population and critical concerns: These include a historical study and some systematic and scoping reviews on particular health communication issues.
5. Mixed methods research was also employed.

### **Health communication research in other parts of sub-Saharan Africa**

Table 3 shows publications on other regions of Africa, highlighting the country most in focus, health topics, authors' affiliation, theories as well as research methodologies. The countries most studied were South Africa and Uganda. As seen from articles published in West Africa, only nine articles (*Health Communication*, n=5; *Journal of Health Communication*, n=4) dealt in issues pertaining to Africa. The most researched topics were HIV/AIDS and COVID-19 vaccines. However, overall, publications about Africa in the two health communication journals were few in number. This can be attributed to the fact that both journals (*Health Communication* and *Journal of Health Communication*) have low acceptance rates, high numbers of submissions, and high impact ratings, which are indicators of the high quality of research published in them (Thompson, 2014).

Sub-Saharan Africa carries the highest burden of HIV/AIDS-related mortality in the world (Limage et al., 2014). Other health areas of concern are family planning, malaria, Ebola, Lassa fever, and, more recently, COVID-19. Furthermore, a strong constituency around maternal mortality, the advent of the global fund, and the push for polio eradication provided some balance, with increased support and resources emerging for health communication in the areas of safe motherhood, malaria, tuberculosis and polio (Limage et al., 2014). South Africa enjoys greater access to advanced overall healthcare than any country in the southern part of Africa, but this access is disproportionately distributed to members of the wealthiest upper class (Gerdes & Basu, 2014). Uganda was reported to have had one of the best healthcare systems in Africa during the 1960s but civil unrest following a military coup led to economic declines in the 1970s and 1980s that adversely affected the once primarily government-funded healthcare system (Wilkin, 2014). Countries with the

**Table 3:** Health communication research in other regions of Africa as shown in the sampled journals

Journal(s)	Country	Health communication topics	Author(s) affiliation	Theory	Research Methodologies
<i>Journal of Health Communication</i>	South Africa (1); Country level analysis (1); Kenya (2);	HIV/AIDS (2); COVID-19 vaccines (2)	Interdisciplinary (1); medical (2); communication scholars (1)	Protection motivation theory (1); extended parallel processing model	Quantitative (3); qualitative (1)
<i>Health Communication</i>	Uganda (2); South Africa (1); Mozambique (1)	Maternal health (1); mental illness (1); intercultural health interactions (1); entertainment education radio programme (1)	Communication scholars (3); interdisciplinary (1)	Hybrid sociolinguistic approach (1)	Quantitative (1); qualitative (2); mixed methods (1)

Journal(s)	Country	Health communication topics	Author(s) affiliation	Theory	Research Methodologies
<i>BMC Public Health</i>	Uganda (11); sub-Saharan region) (2); South Africa (10); Rwanda (3) Ethiopia (7); Tanzania (3); Sudan (1); Kenya (3); Botswana (2); Zambia (2); Lesotho (1); DRC (1); Malawi and South Africa (1) Ghana and Kenya (1)	Diabetes (1) HIV/AIDS (12); alcohol vaccines (1); COVID-19 planning (1); infant feeding (1); tuberculosis (2); childhood stunting (1); malaria (3); violence prevention programme (1); maternal, newborn & child health (1); intestinal schistosomiasis (1); HPV vaccination (1); stroke (1) sexual & reproductive; health (7); immunisation (1); food and beverage advertising (1); Sugary beverage tax (1); HIV and obesity (1); Parent-child communication (1); hand hygiene (1); hypertension (1); cervical cancer (1).	Interdisciplinary (24) medical (29)	Diffusion of innovations (1)	Review (3) quantitative (31) qualitative (14) mixed methods (3)
<i>PLOS Global Public Health</i>	Tanzania (2); Ethiopia (6); Kenya (2); sub-Saharan region) (3) DRC (1) Ethiopia (7); Burundi (1) South Africa (2) Rwanda (2) Uganda (1) Zimbabwe (1); Nigeria and Kenya (2)	Alcohol (1); infant vaccination (1); stillbirth and neonatal mortality (1); substance use (1); maternal health (1); health information-seeking behaviour (1); cholera (1); reproductive health (1); contraceptives (1); COVID-19 (2); malaria (1); dog vaccination (1); family planning (1); Rift Valley fever (1); routine health information (1); hepatitis (1); cancer (1); homebirths (1); primary healthcare (1)	Medical (10) interdisciplinary (14)	None	Qualitative (6) quantitative (16) mixed methods (1) review (2)

highest HIV prevalence include Swaziland, Botswana, Lesotho, South Africa, Zimbabwe, Namibia, Zambia and Mozambique (Kim & Chikonbero, 2014). According to the 2011 Uganda Ministry of Health assessment, malaria, HIV/AIDS, and pneumonia were the leading causes of death, while malaria, anaemia, and pneumonia are the leading causes of death for children under the age of five.

While there are similarities in the topics treated in West Africa and other parts of sub-Saharan Africa, one particular topic that stands out is COVID-19. The COVID-19 pandemic has made it clear that effective public health messaging is an indispensable component of a robust academic response system (Nan et al., 2022). Findings revealed that the issue was missing in studies on West Africa. However, it received considerable attention across other parts of sub-Saharan Africa. The use of theory used differed across the regions: only the extended parallel processing model and diffusion of innovations theory were common. In the same vein, quantitative research methodology was also prominent in both regions.

### **Decolonisation of health communication research in Africa**

Issues in equity and power asymmetry in global partnerships are driving the current discussion of decolonising global health (Finkel et al., 2022). Coloniality restricts understandings of relations and their importance to communication by making persons, actions, and contexts seem individuated and autonomous (Hanchey & Asante, 2022), hence the need to decolonise research. The movement to decolonise global health encompasses efforts to dismantle historically inequitable structure and processes in global health education, research and practice (Ngaruiya et. al., 2024). This is because pedagogies in media and communication studies can draw and benefit from efforts to decolonise other academic disciplines and vice versa (Batisal, 2024) as folk media, an indigenous form of cultural knowledge, can be a strong, replicable, culturally grounded, decolonising research methodology that promotes collaboration and the deconstruction of power relations (Abdulla, 2024). In addition, African knowledge systems and communicative patterns that emerge from the interactions between African people, and with global

and local institutions, can reveal both the limitations of neoliberal capitalist logics and some African knowledge systems (Hanchey & Asante, 2022). An appraisal of global health trends reveals that certain people, communities and populations enjoy better health than others, and that these disparities often occur along the historical lines of the coloniser versus the colonised that emerged during the 200 years of European imperialism (Sastry, 2014).

A publication in *PLOS Global Public Health* titled *Colonialism, Malaria and Decolonization* discussed how malaria and other aspects of global health could be decolonised and suggested directions for future analysis that can lead to concrete action. The researchers (Bump & Aniebo, 2022) assert that prominent journals and leading authors of global health research are largely associated with the United States, the United Kingdom, and other colonial powers, even as their works are largely concerned with formally colonised places and people. This is true for the majority of research on Africa, where the authors are affiliated to universities outside the continent. Also, the review of these journals showed that most of the researchers were domiciled in institutions outside the country, particularly the United States and United Kingdom. For example, Thompson and Ofori-Parku's (2020) work is on *Advocacy and mobilizing for health policy change: Ghanaian news media's framing of a prescription Opioid crisis*, but the authors are affiliated to Indiana University and the University of Oregon respectively. Furthermore, a look at the editorial board of the individual journals shows little representation of Africans. Regarding the editorial board of *Health Communication*, the editor-in-chief and associate editor-in-chief are affiliated with universities in the United States. Others were from South Korea, Switzerland, United Arab Emirates, and Singapore, with one scholar affiliated to a university in Israel. The editorial board of the *Journal of Health Communication* had a similar composition as *Health Communication*, with the majority of scholars from the United States and none from Africa. However, the two public health journals (*BMC Public Health* and *PLOS Global Public Health*) both had Africans on their editorial boards. The *PLOS Global Public Health* editors-in-chief are affiliated with institutions in Kenya, Canada and the United States respectively. This will affect the

number of articles accepted by these journals and is perhaps one of the reasons why there is a paucity of articles about and from Africa in the two health communication journals.

The issue of decolonisation in global health has been based on the premise that there are unfair outcomes in the coverage of global health. While there is general agreement amongst those involved in global health partnerships that the current system needs to be made more equitable, suggestions for how to address the issue of decolonisation vary greatly, and moving from rhetoric to reform is complicated (Finkel, et.al., 2022). Olaoye and Onyenankeya's (2023) review of health communication strategies in sub-Saharan Africa suggests a need for more traditional health communication strategy based on indigenous knowledge systems, while global health promotion campaigns, on the other hand, see Africans as not wanting to adopt modern health behaviours as they cling to their traditional cultural beliefs. However, Bump and Aniebo (2022) cautioned that decolonisation is not fundamentally a rejection of knowledge accumulation under colonial arrangements, nor a return to pre-colonial conditions; instead, it is a question of how we change objectives and accountabilities in favour of development and autonomy, and how we use that knowledge to move away from the production of inequality and dependency.

### **Challenges to health communication research in Africa**

Africa bears a disproportionately high burden of globally significant disease but has lagged in knowledge production to address its health challenges (Kasprowicz et al., 2020). There are inherent challenges militating against African scholarship in the area of health communication. They include:

#### *a. Poverty in the region and paucity of funds*

The high cost of publishing in these journals together with the poverty in the region accounts for the low number of articles. Echoing this, Amutahaire (2022) and Kigotho (2021) observed that the high publication fees, which represent a large portion of the monthly payment of a researcher from Africa, deter some

from producing a desirable number of publications or make them publish in journals with a lower impact factor. Tarkang and Bain (2019) succinctly captured it thus:

In a rapidly growing scientific world and in the internet age we find ourselves today, coupled with the poverty situation in Africa, most consumers of research go for open access journals where they can access information free of charge even via their electronic devices. This has left most scientists and researchers in Africa with no choice than to publish in open access journals with the challenge of paying publication fees. The high financial cost of publishing in some international peer reviewed open access journals means that much of the research done in Africa remains invisible to the rest of the world because of the inability for most scientists in Africa to afford publication fees.

While sub-Saharan Africa spends little on healthcare, it is worth noting that the region continues to experience significant population growth, which poses serious challenges to socioeconomic development by forcing governments to meet the needs of young people (Byaro et al., 2022).

*b. Prolonged peer review process*

Africa accounts for only 2% of the world's research output (Tarkang & Bain, 2019), and this can be attributed to the peer review processes involved in publishing in reputable journals. This is a daunting task for African scholars, as these journals might take up to two years to publish an article, by which time the article is somewhat out of date. A typical example is the COVID-19 pandemic and vaccine hesitance and acceptance. Only a few studies in Africa addressed this issue in the journals sampled.

*c. Sparse visibility of research published in African journals*

Another challenge arising from the above-mentioned, as articulated by Murray (2014) is Africa's sparse visibility in research, which arose from the need to offer printed versions of journals published in Africa, unlike the rest of the world. This has

placed many good African journals in the lowest quartile when it comes to journal rankings. African researchers do not get the chance to benchmark their publications, hence their low quality and failure to appear in high-impact journals (Amutahaire, 2022). Despite the radical shift of academic publications transitioning into both digital and hard copy format, African researchers, students and other stakeholders are constrained by the cost of processing fees and journal subscriptions (Kigotho, 2021).

*d. 'Publish or perish' syndrome*

The pressure mounted on the African scholar to 'publish or perish' is another problem associated with low publications in reputable journals. This issue has led to African researchers failing prey to predatory journals. In some cases, they become merchants of their intellectual property, where they either 'sell' a space by adding their colleagues' names to their journal articles or pay to add theirs to an already-produced article. In addition, the need to publish has drastically affected the quality and relevance of research in the continent as researchers are not concerned with solving or proffering solutions to problems via research.

These challenges do not advance scholarship, especially in the area of health communication, as it can move public health from a diagnose-and-treat model of medicine to a predict-and-prevent model, with public health and communication central to promoting health and well-being (Limage et al., 2014). However, it is important to note that these journals give waivers of up to a 100% for articles accepted, especially if the authors are based in institutions in developing countries.

## **Conclusion**

Health communication is an integral part of society, as information about health and well-being can be communicated to communities and can facilitate health education and promotion. It studies messages and campaigns that create meaning in respect of physical, mental and social well-being. As such, it is a very important aspect of communication. Africa has been plagued by several diseases and health challenges, thus emphasising the need

for health communication research published in international journals of repute. However, this study of four prominent journals of health communication and public health shows a marked paucity of research about Africa. The health-related topics reflected most of the more traditional health challenges prevalent in the region, with the issue of COVID-19 being absent in studies on the West African region. Also, very few studies on the region used theory, while different methodologies were employed.

In addition, the issue of decolonisation of health communication research was discussed, with the findings of the study showing that most of the research was conducted by scholars from the United States and United Kingdom respectively. Furthermore, the challenges faced by African communication scholars include poverty in the region and a paucity of funds, the prolonged peer review process, sparse visibility of research published in African journals and the 'publish or perish' syndrome.

As part of a paradigm shift, attention needs to be paid to creating a more equal and equitable representation of researchers from developing countries in decision-making, leadership roles, authorship, and funding allocations (Finkel et al., 2022). The small grants given by African governments and philanthropies are not enough to improve research in the region. This has led to the invisibility of African research, as it is doubtful if there is any information flow to those outside academia (Onyeka, 2014). Given the decrease in global health funding, there has been a greater focus on the mobilisation of local resources as well as a call for local populations becoming involved in health (Ndiaye & Diouf, 2014).

However, the limitation of this study is that African journals on health communication or public health were not included. Future studies could assess articles in journals published in Africa and about Africa. Such research could also investigate scholars from other continents' contribution to health communication in those journals. Secondly, African health communication scholars can advocate for the juxtaposition of traditional communication strategies and Western media approaches. This will help

disseminate pertinent health information to those in the remote parts of Africa.

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