Chapter 5

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

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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 te 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.

References

Agardh, A., Emmelin, M., Muriisa R. & Östergren, P. 2010. Social capital and sexual behavior among Ugandan university students. *Global Health Action*, 3(5432):1–13. DOI: https://doi.org/10.3402/gha.v3i0.5432

Aluzimbi, G., Barker, J., King, R., Rutherford, G., Ssenkusu, J.M., Lubwama, G., Muyonga, M. & Hladik, W. 2013. Risk factors for unplanned sex among university students in Kampala, Uganda: A Qualitative Study. *International Journal of Adolescence & Youth*., 18(3):191–203. DOI: https://doi.org/10.1080/02673843.2012.685947

Amanya, S.B., Nakitende, J. & Ngabirano, T.D. 2018. A cross-sectional study of stress and its sources among health professional students ate Makerere University, Uganda. *Nursing Open*, 5(1):70–76. DOI: https://doi.org/10.1002/nop2.113

American College Health Association (ACHA). 2014. *Healthy Campus 2020*. [online]. Available from: https://www.acha.org/healthycampus

Bernhardt, M.J. 2004. Communication at the core of effective public health. *American Journal of Public Health*, 94(12):2051–2053. DOI: https://doi.org/10.2105/ajph.94.12.2051

Brener, N.D. & Gowda, V.R. 2001. US college students' reports on receiving health information on college campuses. *Journal of American College Health*, 49(5):223–228. DOI: https://doi.org/10.1080/07448480109596307

Byamugisha. K.J., Mirembe, F., Faxelid, E. & Gemzell-Danielson, K. 2006. Emergency contraception and fertility awareness among university students in Kampala, Uganda. *African Health Sciences*, 6(4):194–200. DOI: https://doi.org/10.5555/afhs.2006.6.4.194

Bryman, A. 2016. *Social research methods*. 5th edition. Oxford, UK: Oxford University Press.

Came, A.H. & Tudor, K. 2020. The whole and inclusive university: A critical review of health promoting universities from Aotearoa New Zealand. *Health Promotion International*, 35(1):102–110. DOI: https://doi.org/10.1093/heapro/day091

Campbell, C. & Scott, K. 2012. Community health and social mobilisation. In: R. Obregon & S. Waisbord (eds.), *The handbook of global health communication*. Oxford UK: Wiley-Blackwell. (pp. 177-193). https://doi.org/10.1002/9781118241868.ch8

Choudhry, V., Agardh, A., Stafström, M. & Östergren, P. 2014. Patterns of alcohol consumption and risky sexual behavior: a cross-sectional study among Ugandan university students. *BMC Public Health*, 14(2014):128. DOI: https://doi.org/10.1186/1471-2458-14-128

Corcoran, N. 2013. *Communicating health: Strategies for health promotion*. 2nd edition. London: SAGE Publications. https://doi.org/10.4135/9781526401588

Darabi, L., Bankole, A., Serumaga, K., Neema, S., Kibombo, R., Ahmed, H. & Banoba, P. 2008. *Protecting the next generation in Uganda: New Evidence on adolescent sexual and reproductive health needs*. New York: Guttmacher Institute.

Darker, C.D., Mullin, M., Doyle, L., Tanner, M., McGrath, D., Doherty, L., Dreyer-Gibney, K., Barrett, E.M., Flynn, D., Murphy, P., Ivers, J.H., Burke, E., Ryan, M., McCarron, M., Murphy, P., Sheils, O., Hevey, D., Leen, A., Keogh, L., ... Barry, J.M. 2021. Developing a health promoting university in Trinity College Dublin – Overview and outline process evaluation, *Health Promotion International*, 38(4):1-14. DOI: https://doi.org/10.1093/heapro/daab180.

Dooris, M. 2002. The health-promoting university: Opportunities, challenges and future development. *Promotion and Educcation*, 9(Suppl 1):20-24. DOI: https://doi.org/10.1177/10253823020090010112

Dooris, M. 2013. Expert voices for change: bridging the silos-towards healthy and sustainable settings for the 21st century. *Journal of Health & Place*, 20(2013):39-50. DOI: https://doi.org/10.1016/j.healthplace.2012.11.009

Edgar, T. Freimuth, V. & Hammond, S.L. 2003. *Lessons learned from the field on prevention and health campaigns*. New York & London: Routledge.

Egerö, B. 2006. HIV/AIDS on the campus: universities and the threat of an epidemic. *Eastern Africa Social Science Research Review,* 22(2):31–50. ISSN: 1027–1775. https://doi.org/10.1353/eas.2006.0006

Emyedu A., Babua, P., Nabukalu, J., Mugarura, D., Ochwo, C., Nahereza, T.I., Ssinabulya, I. & Wabinga. H. 2017. Assessing Knowledge about the Dangers of Alcohol Consumption: A Cross-sectional Descriptive Study, among Makerere University Undergraduate Students. *Journal of Health Science,* 5(2017):21–127. DOI: https://doi.org/10.17265/2328–7136/2017.03.001

Green, W.L., Poland, B. & Rootman I. 2000. The settings approach to health promotion. In: B.D. Poland, L.W. Green & I. Rootman (eds.), *Settings for health promotion: Linking theory and practice*. London: SAGE Publications. (pp, 1–43). https://doi.org/10.4135/9781452232829.n1

Griner, B.S., Vamos, A.C., Phillips, C.A., Puccio, A.J., Thompson, L.E. & Daley, M.E. 2021. Assessing college students' interest in university-based oral health information and services. *Journal of American College Health*, 71(1):5–9. DOI: https://doi.org/10.1080/07448481.2021.1876706.

Hatfield, P. D., Sharma, S., Bailey. P.C., Bakan, P., Hennessy, E., Simon, C. & Economos, C. 2024. Implementation of nutrition and physical activity-related policies and practices on college campuses participating in the healthier campus initiative. *Journal of American College Health*, 72(4), 1192–1199. https://doi.org/10.1080/07448481.2022.2071617

Hill-Mey, E.P., Kumpfer, L.K., Merrill, M.R., Reel, J., Neville, H.B. & Richardson, E.G. 2015. Worksite health promotion programs in college settings. *Journal of Education and Health Promotion*, 4(2015):12. DOI: https://doi.org/10.4103%2F2277–9531.154019

Institute of Medicine. 2002. *Speaking of health: Assessing health communication strategies for diverse populations.* Washington, DC: The National Academies Press. DOI: https://doi.org/10.17226/10018.

Kaaya. S.F., Mukoma, W., Flisher, A.J. & Klepp, K.I. 2002. School-based sexual health interventions in sub-Saharan Africa: A review. *Social Dynamics*, 28(1):64-88. DOI: https://doi.org/10.1080/02533950208458723

Kaggwa, M.M., Arinaitwe, I., Muwanguzi, M., Nduhuura, E., Kajjimu, J., Kule, M., Najjuka, S., Nkola, R., Ajuna, N., Wamala, N.K., Machacha, I., Mamun, M.A., Ho, C.S., Griffiths, M.D. & Rukundo, G.Z. 2022. Suicidal behaviours among Ugandan university students: A cross-sectional study. *BMC Psychiatry*, 22(1):234. DOI: https://doi.org/10.1186/s12888-022-03858-7

Kamulegeya, H.L., Kitonsa, J.P., Okolomong, E., Kaudha, G., Maria, S. & Nakimuli-Mpungu, E. 2020. Prevalence and associated factors of alcohol use patterns among university students in Uganda. *Pan African Medical Journal*, 37(2020):(339). DOI: https://doi.org/10.11604/pamj.2020.37.339.21136

Kasozi, A.B.K. 2016. The status of research at three Ugandan universities. In: T. Halvorsen & J. Nossum (eds). *North-South knowledge networks: Towards equitable collaboration between academics, donors and universities*. Cape Town: African Minds.

Macnab, A. 2012. The Stellenbosch consensus statement on health promoting schools. *Global Health Promotion*, 20(1),78–81. DOI: https://doi.org/10.1177/1757975912464252

Martínez-Bello, E.V., Martínez-Rojas, A. & Molina-Garcia, J. 2016. Health-related messages about physical activity promotion: An analysis of photographs on social networking sites of universities. *Journal of Higher Education Policy and Management*, 39(1):75-88. DOI: https://doi.org/10.1080/1360080X.2016.1254428

McCartney, G., Popham, F., McMaster, R. & Cumbers, A. 2019. Defining health and health inequalities. *Public Health*, 172(2019):22-30. DOI: https://doi.org/10.1016/j.puhe.2019.03.023

McDonald, H., Gould, R., Delaney. D. & Vecchio, N. 2021. An investigation of the health-promoting practices of Australian Universities. *Health Promotion International,* 36(5):1403-1412. DOI: https://doi.org/10.1093/heapro/daab004

Mehra, D., Agardh, A., Petterson O.K. & Östergren. P. 2012. Non-use of contraception: determinants among Ugandan university students, *Global Health Action*, 5(2012):18599 DOI: https://doi.org/10.3402%2Fgha.v5i0.18599

Muwanguzi, M., Kaggwa, M.M., Najjuka, S.M., Mamun, M.A., Arinaitwe, I., Kajjimu, J., Nduhuura, E. & Ashaba, S. 2023. Exploring adverse childhood experiences (ACEs) among Ugandan university students: Its associations with academic performance, depression, and suicidal ideations. *BMC Psychology*, 11(1):11. DOI: https://doi.org/10.1186/s40359-023-01044-2

Naamara, W. & Muhwezi, W.W. 2014. Factors associated with alcohol dependence among adult male clients in Butabika Hospital, Uganda. *Journal of Social Work Practice in the Addictions,* 14(3):322-6. DOI: https://doi.org/10.1080%2F1533256X.2014.936251

Najjuka M.S., Checkwech, G., Olum, R., Ashaba, S. & Kaggwa, M.M. 2021. Depression, anxiety and stress among Ugandan University students during the Covid-19 lockdown: an online survey, *African Health Sciences*, 21(4):1533-43. DOI: https://doi.org/10.4314/ahs.v21i4.6

Nalwanga, R., Nuwamanya, E., Nuwasiima, A., Babigumira, J.U, Asiimwe, F.T. & Babigumira, J.B. 2021. Utilization of a mobile phone application to increase access to sexual and reproductive health information, goods, and services among university students in Uganda. *Reproductive Health*, 18(95), 95 (2021). DOI: https://doi.org/10.1186/s12978-020-01037-z

New Vision. 2022. *14 million Ugandans have mental disorders - report*. (13 May 2022) [online]. Available from https://www.newvision.co.ug/category/news/14-million-ugandans-have-mental-disorders-rep-133833

Obregon, R. & Waisbord, S. (eds.), 2012. *The handbook of global health communication*. Oxford: Wiley-Blackwell. https://doi.org/10.1002/9781118241868

Okahaabwa, G., Tweheyo, A.N., Ziryawulawo, P. & Kukugiza, D. 2020. Initiation and prevalence of substance use and abuse among university students in Uganda. *African Journal of Clinical Psychology*, 2(3)1-18. Available from: https://www.daystar.ac.ke/ajcp/download/53/1662550863_Gooreka-Okahaabwa.pdf

Olum, R., Nakwagala, N.F. & Odokonyero, R. 2020. Prevalence of factors associated with depression among medical students at Makerere University, Uganda. *Adv Med Edu Pract*., 11(2020):853-860. DOI: https://doi.org/10.2147/amep.s278841

Ovuga, E., Boardman, J. & Wasserman, D. 2006. Undergraduate student mental health at Makerere University. *World Psychiatry*, 5(1):51-52. PMID: 16757997.

Parcel, G.S., Kelder, S.H. & Basen-Engquist, K. 2000. The school as a setting for health promotion. In: B.D. Poland, L.W. Green & I. Rootman (eds.), *Settings for health promotion: Linking theory and practice*. London: SAGE Publications. (pp. 86-119). https://doi.org/10.4135/9781452232829.n3

Quiroz Flores, A., Liza, F., Quteineh, H. & Czarnecka, B. 2021. Variation in the timing of Covid-19 communication across universities in the UK. *PLoS One*, 16(2):e0246391. DOI: https://doi.org/10.1371/journal.pone.0246391.

Ray, C. E., Perko, A., Oehme, K., Arpan, L., Clerk, J. & Bradley. 2023. Freshmen anxiety and COVID-19: Practical implications from an online intervention for supporting students affected by health inequalities. *Journal of American College Health*, 71(7), 2234-2243. DOI: https://doi.org/10.1080/07448481.2021.1965610

Rimon, J.G. 2001. *Behaviour change communication in public health. Beyond dialogue: moving toward convergence*. [online]. Available from: https://www.comminit.com/power_point_downloads/rimon.ppt

Sarmiento, J.P. 2017. Healthy universities: Mapping health-promotion interventions. *Health Education*, 117(2):162-175. DOI: https://doi.org/10.1108/HE-07-2016-0028

Sihotang, J., Amri, S. & Vinsensia, D. 2024. Exploring the intersection of HIV/AIDS knowledge and rapid testing attitudes in higher education: A student perspective. *Community Service & Applied Research*, 1(1), 1–17

Springston, K.J. & Lariscy, A.R. 2003. Health as profit: Public relations in health communication. In: T. Thompson., A. Dorsey., K. Miller & R. Parrot. *Handbook of health communication.* London: LEA. (pp. 537–582).

Swahn, M.H., Ali, B., Palmier, J., Tumwesigye, M., Sikazwe, G., Twa-Twa, J. & Rogers, K. 2011. Early alcohol use and problem drinking among students in Zambia and Uganda. *Journal of Public Health in Africa*, 2(2):e20. DOI: https://doi.org/10.4081%2Fjphia.2011.e20

Sundstrom, B., Brandt, H.M., Gray, L. & Young Pierce, J. 2018. It's my time: Applying the health belief model to prevent cervical cancer among college-age women. *Journal of Communication Management*, 22(2):161–178. DOI: https://doi.org/10.1108/JCOM-06-2016-0044

Teferra, D. 2003. Scientific communication in African universities: External assistance and national needs. New York & London: Routledge. https://doi.org/10.4324/9780203498699

Uganda AIDS Commission (UAC). 2018. *Acceleration of HIV prevention in Uganda: A road map towards zero new infections by 2030*. [online]. Available from: https://uac.go.ug/media/attachments/2021/12/08/prevention-road-map-final.pdf

Uganda Ministry of Health (MoH) and International Classification of Functioning, Disability and Health (ICF). 2012. *2011 Uganda AIDS indicator survey: Key findings*. Calverton, Maryland, USA: MOH and ICF International. Available from: https://www.dhsprogram.com/pubs/pdf/SR194/SR194.pdf

Wang, Q., Zhang, W. & An, S. 2023. A systematic review and meta-analysis of internet-based self-help interventions for mental health among adolescents and college students. *Internet Interventions,* 34, 100690. DOI: https://doi.org/10.1016/j.invent.2023.100690

Waters, R.D., Canfield, R.R., Foster, J.M. & Hardy, E.E. 2011. Applying the dialogic theory to social networking sites: Examining how university health centers convey health messages on Facebook. *Journal of Social Marketing*, 1(3):211–227. DOI: https://doi.org/10.1108/20426761111170713

Wordlaw, L. & Vilme, H. 2024. Lessons learned: Implementing and adapting a multimedia campaign to promote heart health to college students. *Journal of American College Health*, 72(2), 493–499. DOI: https://doi.org/10.1080/07448481.2022.2041644

World Health Organization (WHO). 1986. *The Ottawa charter for health promotion*. [online]. Available from: https://www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference

World Health Organization (WHO). 2011. *World Health Organization global status report on alcohol and health*. [online]. Available from: https://iris.who.int/bitstream/handle/10665/44499/9789241564151_eng.pdf?sequence=1

Yager, Z. & O'Dea J. 2008. Prevention programs for body image and eating disorders on university campuses: A review of large, controlled interventions. *Health Promotion International*, 23(2):173–189. DOI: https://doi.org/10.1093/heapro/dan004