

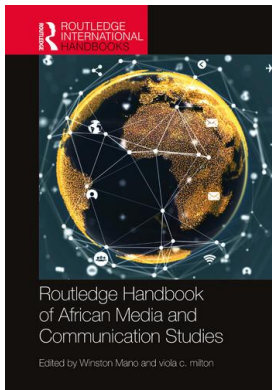
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Health communication in Africa

Elizabeth Lubinga and Karabo Sitto

Introduction

Health communication is an emerging field within the broader study of communication. Health communication occurs in various contexts; intrapersonal, interpersonal, small group, organisational, mass and public. This chapter focuses on and operationalises communication for health as interpersonal when occurring between healthcare provider and patient; small group among teams of healthcare professionals; within organisational settings such as hospitals, clinics or health promotion and education organisations and at mass or public level often involves the media. This chapter mostly addresses the interpersonal, organisational and mass contexts, because communication in these core appears to affect most of Africa's population in relation to existing health needs.

Nonetheless, the chapter briefly addresses other contexts of communication. The two main contexts, both pillars of health communication – mass and interpersonal – rarely interface. Interpersonal interaction between health practitioner, whether nurse, doctor or traditional healer in the African context, and their patient(s), offers a personalised approach and appears to run parallel to mass communication. On the other hand, messages communicated to the public by governments through health departments, by health promotion organisations and other interested international and national parties, are often homogenous, yet in Africa, target broad heterogeneous audiences. It is factors such as inequitable rates of literacy, mostly rural populations; lack of access to health care and related facilities; as well as cultural barriers among others, that influence the heterogeneous nature of target audiences. Linguaging in health messages presents an ever-present barrier in Africa, given the framing of the messages in *lingua francas* such as English, French, Portuguese, Swahili and Lingala for example and subsequent translation into multiple African indigenous languages. In addition, the indirect communication of sensitive health-related content in an attempt by healthcare providers, health promotion organisations and governments to accommodate cultural taboos and stigma, often results into a loss of message meaning.

The chapter commences with a contextualisation of health communication, with a focus on mass communication at international, African regional and national levels. A critique of some major commonly cited existing Western health communication theories, as often applied to African contexts, is conducted. The critique raises questions about the need for African scholars to conceptualise newer fit-for-purpose health models in order to augment the existing

culturally relevant PEN-3 Cultural Model developed by Airhihenbuwa in 1989. Notions of culture and activism and their influence on health communication are scrutinised as well as the introduction of artificial intelligence and robotics' growing use and effects of information and communication technologies (ICTs).

Contextualising health communication in Africa

Various players operate in the field of health in Africa. At a global level, organisations whose funding for health-related and other needs is solicited from multiple governments and non-governmental sources and is distributed among many different countries are classified as multi-lateral, as is the case of the World Health Organisation (WHO). Global health organisations typically map out areas of policy development and research, which countries are often required to adhere to; offer technical support to governments or non-governmental organisations (NGOs); and engage in advocacy. The dynamics between WHO and various countries were emphasised in 2020, when the organisation pronounced COVID-19 as a pandemic on 11 March (WHO 2020a). The pronouncement of pandemic attested to the global spread but also required individual countries to put measures into place to mitigate the risk of spread. Global organisations hardly formulate messages targeting national audiences, but often require accountability from various countries regarding the implementation of health-related programmes.

Bilateral agencies such as the United States Agency for International Development (USAID) are government agencies or non-profit organisations (NPOs) based in a single country and provide funding to developing countries. For example, in South Africa, for HIV/AIDS, the USAID has partnered with the South African government at various levels, faith-based organisations (FBOs) and NGOs to provide training and support for personnel working with people living with HIV/AIDS. Specifically, the USAID has sponsored provision of antiretroviral treatments to over 1.4 million people and supported other organisations such as President's Emergency Plan for AIDS Relief (PEPFAR) in providing care and support services to more than 2 million HIV-infected people (USAID 2018).

At the regional level in Africa, bodies such as the Economic Community of West African States (ECOWAS) and Southern African Development Community (SADC) have formulated health-related policies to cater for the health needs of their citizens. For instance, SADC has a Health Policy Framework, which proposes policies, strategies, and priorities in areas such as health research and surveillance; health information systems; health promotion and education; HIV and AIDS and sexually transmitted diseases as well as communicable and non-communicable disease control, among others (SADC 2012).

In individual African countries, NGOs play a pivotal role in providing support for health care. NGOs are non-profit, voluntary citizens' groups organised at the local, national or international level, such as Doctors Without Borders/Médecins Sans Frontières. The NGOs are often task-oriented and usually organise based on particular issues such as health, among others. In South Africa alone, there are more than 100,000 registered non-profit organisations, while in Kenya the number of NGOs grew by over 400 percent between 1997 and 2006 (The Conversation 2017). Because they operate at national levels, NGOs typically construct and disseminate homogenous messages to their target audiences. Such messages are often ineffective because audiences may not understand them, or such NGOs conceptualise the messages internationally and transfer the same ideas to national contexts. Such was the case of health promotion organisation loveLife, which ran provocative HIV/AIDS campaigns between 2000 and 2009 in South Africa with concepts that were too complex for targeted audiences to comprehend or were too culturally explicit for certain segments of those audiences. The motivations put forward by

loveLife for the use of such messages, taken from numerous media interviews and coverage, was their desire to shock the public into speaking about the “incommunicable” issues surrounding HIV and AIDS. As Refilwe Africa, then editor of loveLife’s *Uncut Magazine* stated,

We want people to think about our posters. Either they understand it from first-hand or they get angry and say: I do not know what you are trying to say. At some point in our campaign, we will get people to wonder. This creates conversation between parents and children, dialogue between peers.

(Holleman 2005)

At no point were their communication tactics strategies linked to or substantiated by them through any communication theories that may have informed their communication execution. In a literature review conducted on their programmes, there was a recognition that their subsequent messaging needed to change significantly from their entry into South Africa, informed by research outcomes in their target communities (loveLife 2010).

Contemporary health theories: fit for African contexts

The dominant health communication theoretical approaches that are central to the understanding and prediction of media campaigns are behavioural theories. Behavioural theories are distinct from other bodies of theory. They focus on the individual’s behaviour change, describe relationships between constructs and inherently offer guidance for implementation of health campaigns by organisations and other players that use them in applied, practical settings. Dominant behavioural theories like the Health Belief Model (HBM) (Janz and Becker 1984; Rosenstock 1974), the Theory of Reasoned Action (Fishbein 1980; Fishbein and Ajzen 1975) and the Extended Parallel Process Model (EPPM) (Witte 1992; Witte and Allen 2000) acknowledge that behavioural intentions are important to determining ultimate behaviour. The HBM and EPPM place communication at the centrecore of the promotion and education of health to targeted audiences with predictable results. As they interrogate behaviour, they also attempt to predict the individual’s reaction to health campaign messages. Both theories have been criticised for focusing on the individual and on predicting how each individual is likely to react to messages. They do not take a collectivist stance, thus making them an ill-fit for application to collectivist cultures as are prevalent in African contexts (Dutta-Bergman 2005).

In addition, behaviour change is not always an individual’s decision because there are many other influencing factors such as peers, society, culture and many others.

Airhihenbuwa’s (1989) PEN-3 Cultural Model was developed as a framework for health promotion and disease prevention in African countries, and has over the years, bridged the gap between health communication and culture. The model has three primary domains: Cultural Identity, Relationships and Expectations, and Cultural Empowerment. Each of the domains consists of three elements with an acronym of PEN, which are different for each. For example, the Cultural Identity domain entails human influences including People, Extended Family and Neighbourhoods. The relationships and expectations domain which is about perceptions and attitudes towards health problems includes: Perceptions, Enablers and Nurturers, while the Cultural Empowerment domain identifies and examines the role of Positive, Existential and Negative cultural beliefs and practices in affecting a person’s health behaviour (Iwelunmor et al. 2014). It has successfully enabled health research that is culturally responsive because of its particular focus on cultural identity and cultural empowerment, but with consideration of relationships and expectations (Whembolua et al. 2015). The theory promotes culture as an

enabler in the process of empowerment. This culture-centred body of knowledge highlights work by Airhihenbuwa (1995) and Dutta-Bergman (2005), among others. It upholds narratives by marginalised communities and highlights the interaction between agency, culture and structures. It integrates different levels in terms of how structures such as community medical services, transportation and media at micro-levels, as well as policies, civil society organisations and media platforms at meso-level and at macro level how national and international bodies interact and drive policy formulation (Dutta 2008).

In terms of the way forward concerning developing other culturally responsive theories relevant to the African context, for consideration is positioning the important, yet oft unrecognised role of traditional doctors and traditional (herbal) medicine. It is common knowledge that common practice among many Africans when faced with disease is that patients may use both traditional and Western medicine concurrently or interchangeably. A bidirectional relationship thus exists in praxis among patients, between traditional and Western medicine. For consideration too is the idea of whether a hybrid between dominant Western behavioural theories and cultural approaches would be relevant to the research of health communication in African contexts. After all, health research in Africa has always relied on both paradigms, albeit independently, to answer pertinent questions. Researchers could better consider the role of spirituality and/or beliefs in communicating health and how these influence health behaviour within the African context.

Case Study: the case of Ebola in West Africa

This chapter focuses on Ebola that has intermittently broken out in West, Central and East Africa unlike the more recent global COVID-19. Nonetheless, lessons from the fight against Ebola have been instrumental in the fight against COVID-19 with countries such as the Democratic Republic of Congo, Uganda Nigeria, Gambia and Liberia among others redirecting resources for tracing Ebola cases to COVID-19 (NBC News 2020).

The Ebola breakout in West Africa was announced by the WHO in 2014, reporting cases of Ebola Virus Disease (EVD) in Guinea, marking the beginning of the largest historical epidemic to date which swept across West Africa (CDC 2017a). The epidemic took the world by storm, as patients from across the globe became infected with the deadly virus.

The start of the epidemic in Guinea West Africa was reported under the suspicion that the patient had been infected via an animal, as it is a zoonotic disease. Only after five fatalities was an outbreak official health alert declared, at which point the virus was already spreading across borders in the region to other parts of West Africa. Death rates increased significantly, and it took three months and 29 deaths for the outbreak to be declared by the WHO.

The delay in global alerts being issued about the disease appeared to have accrued from slow interventions in the countries that were initially affected by the earlier cases. Blood testing (the only method of confirming cases of Ebola) received cultural resistance with respect to people's blood being drawn (Dionne 2014). Those that had come into contact with unsuspecting sick people and had become infected moved across borders and there was little monitoring of their movements, nor was there communication of the outbreak. The rallying call of the WHO for the globe to help the worst-affected countries and put monitoring mechanisms in place brought into place the needed interventions.

Standardised messages were developed to inform the world about Ebola and how to possibly identify the disease. Through continuous communication on global news networks, updates on local broadcast channels and health ministries of countries investing in information campaigns were employed to help allay fears of infection and further spreading of the virus. Organisations at risk, from all over the continent, for example in South Africa, South African Airlines, one of

the largest airline carriers in Africa, developed information campaigns for travellers, to reduce panic and respond to customer concerns about various destination countries (Vuso 2014).

Communication about the outbreak became a multidirectional coordinated effort, bringing traditional figures and other cultural influences, multiple countries' politicians, international and local organisations and the modern medical fraternity together in a concerted effort to spread accurate information to people and reduce the global level of panic. With great messaging efforts conducted at all levels of communication, local and global as well as across power spectrums from community members right up to politicians/policy makers, information fell into relevant hands. The powerful key that began to break the chain of information asymmetry about the virus was the involvement of local/traditional leaders and influencers in crafting of the communication messages (CDC 2017a).

In West African countries affected by the outbreak, integrated digital media were used to support on-the-ground efforts to disseminate information, whilst enabling people to participate in mapping where cases were growing (Dionne 2014). Such integrated campaigns included SMS/text messaging campaigns, social media campaigns, word-of-mouth through local traditional leaders and door-to-door digital capturing of suspected cases.

The combined challenges of on-the-ground cultural resistance to the most effective method of diagnosis, as well as delays resulting from politicians' culture of communication often characterised by face-saving, resulted in a delay in combating the Ebola virus. The outbreak was only successfully contained when the communication process involved stakeholders at all levels, was in a language that local people could connect with and involved strict monitoring. Most important was that all the communication was coordinated across multiple media in multiple local languages, in a multidirectional manner.

While the virus is not completely eradicated and a cure or commercially licensed vaccine is yet to be confirmed for the disease, the 2014 outbreak helped put in place communication mechanisms that have made it quicker and easier to contain outbreaks of disease. Screenings at ports of entry, buy-in from critical stakeholders as well as simplified communication to inform communities about the disease have contributed to better surveillance mechanisms across the globe. Establishing communication mechanisms is important because of the intermittent outbreaks of Ebola on the African continent. A study about the latest outbreak in the Democratic Republic of Congo in 2019 shows that a quarter of the participants believe that Ebola is not real (Al Jazeera 2019). For such a highly contagious disease, health workers said that public mistrust, including people concealing symptoms, refusing treatment and vaccines were the biggest obstacles to stopping an epidemic that has reportedly killed more than 630 people from August 2018 to March 2019.

Regulatory environment

Health care is highly regulated, beginning with the various oaths e.g. the Hippocratic Oath that upcoming practitioners are expected to take in order to practice in their chosen medical fields. In addition, various professional bodies monitor and enforce proper practice. This is because human life is at the centre of health care, and the protection of it is central to society. Politicians in Africa hold significant power and influence over communication in general, including health communication. They are able to make and amend laws regulating media content, messaging and placement, including social media. In 2020, politicians in Africa and globally had to evoke disaster laws in individual countries to manage the COVID-19 pandemic with advice from WHO (WHO 2020c). In places such as Uganda and Benin, people on the ground have felt the full might of political power over media as both countries have recently implemented

heavy social media taxes as a disincentive, especially for young people, not to criticise their governments. While Benin has since reversed its decision in response to the different types of protests by the Beninese to the social media tax since its announcement, other countries remain unyielding (Tobor 2018).

Politicians are also in control of budgets allocated towards health communication and decide to invest it in line with policies and political patronage; this includes power over the message communicated, what is expressly said and what is deliberately not mentioned. Political will, particularly in Africa, plays a critical role in health communication and its effectiveness in helping those intended to receive the message.

Many politicians on the African continent are much older than their constituencies, with presidents typically being well over 60 years of age (Kiwuwa 2015), while the median African population age is 19.7 years of age (WorldOMeters 2020). The stark age differences between populations and regulation/policy makers pose challenges particularly in health communication because of a generational divide. Health communication norms in Africa tend to be steeped in a language of age, and communication tactics are perceived to be dated or modernist in approach by recipients of the communication. In such modernist health communication approaches, communication is evaluated in terms of its effectiveness only, and questions of ethics and values are taken for granted (Pal and Dutta 2008), with tools such as scare tactics, fear-mongering, punitive measures, shaming and authoritarianism used to drive intended messages. Uganda's President Yoweri Museveni, who is one of the oldest presidents in Africa, in April 2018 made a public announcement vilifying oral sex, emphatically stating (allAfrica 2018):

Let me take this opportunity to warn our people publicly about the wrong practices indulged in and promoted by some of the outsiders. One of them is oral sex. The mouth is for eating. *Okulya* [to eat in *Luganda*] . . . *chum* (onomatopoeia). The mouth is for eating; not for sex.

Such communication from an aging calibre of African politicians does not allow for effective influence in their engagement with mostly young constituencies about contemporary health issues such as oral sex and alternative sexual orientations that may be drivers of diseases and new diseases arising thereof. This keeps health communication efforts in a passive position of chasing after arising health issues, rather than leading or driving health agendas, often to the detriment of Africans.

These political influences often can filter into and influence the health practitioner's communication boundaries in their interpersonal experiences with patients. The existent power dynamics of practitioner-patient position the communication of healthcare practitioners as authoritative and not to be questioned. These are often entangled with but are sometimes at odds with the legal limitations imposed in most countries on what a healthcare practitioner may ask of patients, and assured confidentiality in their interpersonal engagement with patients. In South Africa for example there are constitutional legal limitations on how and what a healthcare practitioner may ask a patient and the type of environment in which they may do so (HPCSA 2008).

However, abuse of power or authority of voice in consultation rooms is a reported frequent occurrence, and in these settings public health patients do not always have opportunity to engage practitioners through questions about their conditions, courses of treatment, risks, side effects and alternatives. The regulatory environments provide for patients to be informed in order to be able to have control over their health. Patients, if informed, can be empowered to participate meaningfully in helping practitioners manage and treat them back to health, where

thus it becomes a partnership and not simply a reliance on practitioners to be wholly responsible for patients' health statuses.

In addition to systemic regulatory communication burdens, practitioners also have to fight cultural conceptions of them set by traditional healers. They spend a significant amount of time working to earn patient trust before they are able to deliver health communication messages, which may be contradictory of traditional interventions (see case study). There are also challenges of practitioner–patient age gaps, and the manner of overt and covert communication in these interactions.

Patient rights have been globally accepted as involving protection of patients at all costs, in formulation of wording and scope of coverage regarding patient experiences during health-care provision. The enshrined rights govern the power dynamics in health care, dignity preservation of patients, legal recourse for violation of rights, yet on the ground there are often no concrete mechanisms or resources to enforce them. Health communication campaigns may use language that offends recipients, limits their rights or vilifies alternative methods of treatment they may trust, all which sets conditions for rejection of such health communication. Communication of the patients' rights may empower them to feel more in charge and able to ask pertinent questions regarding their course of treatment, which may threaten the influence of healthcare practitioners' communication. Thus, healthcare practitioners may withhold information from their patients in order to preserve their positions of power that are often reinforced by limited resources available to patients e.g. number of doctors, hospitals, medicines etc.

Global bodies like the WHO are central to the critical process of monitoring health communication effectiveness, what efficiencies have been gained and the coordination of knowledge sharing. International Health Regulations were formulated by the WHO in 2005 to help provide concrete guidelines for countries globally on health, and the communication was simplified to include ten steps towards implementation of the regulations. Such regulations have a direct influence on the formulation of communication surrounding health care, as WHO is the overarching body governing health.

Activism for health

At the individual country level, activist or civil society organisations play a crucial role in creating awareness about and finding solutions to health-related problems globally. Typically, most of the global health organisations, such as Doctors without Borders/Médecins Sans Frontières (MSF), the United Nations International Children's Emergency Fund (UNICEF) and CARE International, have a strong presence in Africa because of the various health needs that prevail.

Activist organisations provide a human face to health problems and create visibility for them in societies by fighting for the health rights of marginalised groups. MSF underscores the importance of civil service organisations in its claim that some West and Central African countries have been neglected in terms of global HIV efforts partly because of the limited support role of these organisations (MSF 2016). As a result of fighting for health-related rights, some activist organisations have changed dominant narratives about health problems in countries or have changed national policy. For example in Uganda in 1987, when the HIV/AIDS pandemic was at its peak, the activist organisation The AIDS Support Organisation (TASO) was founded by Noerine Kaleeba together with a group of friends and colleagues, some of whom had been infected by HIV. At the time, there was great stigma about HIV/AIDS in the country, causing the founders to meet informally in secret in each others' homes or offices to provide one

another with mutual psychological and social support. These founder members voluntarily used their time and other resources to visit AIDS patients, carrying them to the hospital for medical attention, while at times they provided basic material and counselling support. These actions paved way for the government to offer stronger support systems for People Living with HIV/AIDS (PLWH) and ultimately lessened societal stigma about the disease.

Benefits to health care as a result of activism by organisations have in some countries been greater than in other countries. In South Africa for instance the HIV/AIDS activist organisation Treatment Action Campaign (TAC), co-founded in 1998 by Zachie Achmat, has been instrumental in campaigning for access for HIV treatment among PLWH. In 2002, the organisation took government to the South African Constitutional Court over provision of treatment and won the case. The South African Constitutional Court ordered the government to provide anti-retroviral drugs to prevent mother-to-child transmission of HIV during birth. The benefits of that achievement were realised long after the case was won. HIV transmission from mother-to-child (MTCT) in South Africa fell to just 1.5 percent in 2015, down from 30 percent in the early 2000s, exceeding the national target of 1.8 percent (AVERT 2015). Today the organisation agitates for various health rights ranging from the provision of better health care by national, provincial and local hospitals and clinics, monitoring national HIV and TB government responses and ongoing provision of access to affordable medicine. In 2017, TAC partnering with over 30 other organisations marched to the national Department of Trade and Industry in Pretoria to hand over a memorandum to the minister asking government to fix the medicine patent laws (#fixthepatentlaws), to enable the use of generic and cheaper medicines for diseases such as cancer in the country.

Activist organisations use various tactics to achieve their goals. For example, the TAC (Yawa 2018) has:

- Engaged in civil disobedience, in which some of members have in the past gone to police stations, to open cases against one-time Minister of Health Manto Tshabalala-Msimang and the Minister of Trade and Industry Alec Erwin in relation to medicine patents.
- Targeted public platforms where a Minister of Health would be addressing people. They would access the meetings with unidentifiable clothing, then would identify themselves during the meeting and pose questions to the minister.
- Mobilised and engaged in protest marches on the streets and to health facilities e.g. to the Department of Trade and Industry.
- Engaged in sit-ins (mobilised about 900 people, gone inside a healthcare facility without interrupting the healthcare services, accessed the administration block and conducted peacefully sit-ins).
- Participated in night vigils and marches against two Provincial Government Health Members of Executive Committee (MECs) in Gauteng and Free State Provinces.
- Arranged pickets, streets marches in which they submitted memoranda to the relevant people.

On the negative side, activism may detract from the actual cause, with society focusing on the tactics employed by organisations rather than communication of the health problems at hand (Lubinga 2020). Health advocacy organisations may also use activism to raise their organisational profile, rendering the activism inauthentic to the cause. Arising from the activities of such organisations as well as growth in computer-mediated communication due to technological advancements, have initiated the growth of online activism, too.

Online health activism

The global growth of the internet has significantly changed the face of activism. People are able to participate in social movements and causes in which they believe in, regardless of their geographic location. The internet has helped surface voices previously not heard (Pal and Dutta 2008) and thus enabled such groups as women, LGBTQI+ communities and young people to surface issues that have previously been silenced, on their health experiences. Online, people can form communities, such as Global Citizen, where people from around the globe may join to contribute towards causes they believe in. These communities use the power of online social communication to pressure governments through coordinated and targeted communication to take action on causes, such as improving health care for women and children, enforcing rights for all with respect to causes such as dignified access to health care, particularly in developing states, including African countries.

These online communities can circumvent controlled media and help highlight on-the-ground issues to global watchdogs and bring them to the attention of other influential bodies. Social activists can use measures to help protect their true identities online to avoid victimisation by authorities and local communities in carrying out their work on issues that may be incommunicable offline. The influence of these online groups is often evidenced in the reactions of governments to social pressures imposed on them by the activities of online social activists, sometimes leading to amendments in policies or the subversion of intended communication. Online health communication activism campaigns have been vibrant. Examples include the drive for provision of free pads for young girls in Africa, better HIV/AIDS medication provision, improved public health systems, male circumcision risks and fat feeding camps for young girls (*leblouh*) in Mauritania. In addition, online activists have campaigned to highlight child marriage health implications for young girls, female genital mutilation and anti-smoking movements, which are just some of the causes that have been fought for vehemently online. These campaigns originate from countries that are far apart on the continent such as Mauritania, South Africa, Malawi and Nigeria, although they have attracted global participation, even though in their countries of origin some activists may suffer limited media access at times.

Whilst social activism online has evolved health communication activist strategies and surfaced issues that may have been suppressed in the past, it is often undertaken at the risk of the lives of leading figureheads of these movements. Online security and access to information has been misused in some countries, like Egypt, by authorities to silence online communities by employing fear tactics, which may include killing the social movement leaders (Acconcia 2018). Often in developing economies, foreign investment or aid can drive motivations in health communication messaging and the execution of underhanded tactics by politicians helping to protect their patrons' industries from threat by social activist communities' causes. The multiplicity of causes being fought online can inadvertently result in audience fatigue (Anderson 2018) and an unfortunate minimisation of the importance of health communication. This has been a concern of the South African Minister of Health regarding the effectiveness of HIV/AIDS communication, his concern is specifically the stubborn infection rate among youth which is still considered to be too high (Sehoai 2018).

Health communication and culture

Communication is culture and culture is communication (Burton and Dimpleby 2006). This statement rings truer when applied to health communication, because people are oft unable

to enjoy health without communication. As already discussed in the theory section, culturally based health approaches have evolved based on the fact that in Africa there can be no effective health communication without consideration of culture.

Barriers to health communication that have been discussed in this chapter such as language exclusion or lack of access to messages in the media or during consultation with health practitioners represent cultural aspects. Language is an element of culture and a social representation of socio-cultural groups. Representations come about as a result of social interaction as well as communication between individuals and groups (Hoiijer 2011), using language as an instrument of expression of thought and feeling. It is through social life that individuals exchange ideas and points of view, generating a positive conflict that helps improve knowledge and this leads to the development of cultural and material tools e.g. language, technology etc. (Tateo and Iannaccone 2012). This applies to health communication, too. As cultures interact and societies become more diverse, health communicators have attempted to develop a language that can convey the gravity of the communication messages. Makalela (2015, 16) points out, “the advent of super diverse settings in the 21st century has increasingly required . . . acknowledg[ing] the linguistic fluidities that overlap into one another.” In the health communication sphere, this requires communicators to be interculturally competent in order to have the appropriate level of sensitivity when working across different cultures with overlapping messages.

Artificial intelligence, social media, mHealth and eHealth: evolving areas in communicating health

The year 2020 pioneered the use of artificial intelligence and robotics in the fight against COVID-19 for health communication in Africa. For example, Rwanda introduced the use of robots to protect health personnel from the contagion. Five human-sized robots, such as Akazuba, Ikirezi, Mwiza, Ngabo and Urumuri, took over roles by medical personnel, among others communicating with patients by detecting people who were not wearing masks and instructing others to wear masks properly (WHO 2020b). In addition, communication technology has grown exponentially, especially over the last decade, spurred by increased globalisation that has driven significant innovation in ICTs. These computer-mediated technologies have been drivers for growth in health industries and have improved health communication. One of the main drivers for this exponential growth has been the ubiquitous proliferation of the mobile phone, in particular, smartphones (Watson, Pitt, Berthon and Zinkhan 2002).

Individuals in developing countries may use mobile devices (mHealth) to access healthcare information, which is posted online, or be able to connect with a healthcare practitioner, without face-to-face interaction. Through search engine optimisation, patients are able to search for online experts in close proximity to them or by specialty or through mobile applications with information portals on a range of health issues. While ICTs, the internet and the devices that facilitate and enhance online interpersonal communication have many benefits, they do also present health communication with some challenges.

Access to information regarding health may make patients feel that healthcare experts are dispensable, to the point that they may choose DIY health care, leading to probable misdiagnoses and misinformation through channels such as health chat forums from the general public online (eHealth). Because communication technologies facilitate a meeting of people from different cultures online, health communication online is not often uniform. The online opinion environment can greatly differ from an individual's offline world in such a way that opinions they come across online are likely to be more diverse (Schulz and Roessler 2012). These technoscapes, which involve the fluidity of technology that makes tangible and intangible

knowledge flows possible across boundaries (Pal and Dutta 2008), are seen as useful for transcending both geographical and social boundaries. They do however still leave out a large cross-section of society who have limited or no access to the internet of the ongoing conversations.

Internet penetration in Africa, as compared to the rest of the world, lags far behind. At the low end of the scale in Africa, Eritrea was reported as having an internet penetration of 1.4 percent at the end of 2017, whilst Kenya was reported as having the highest internet penetration rate in the same period of 85 percent (Internet World Stats 2017). The overall average rate for the continent however is still 20 percent behind the rest of the world. Technoscapes “simultaneously . . . produce an ongoing process of ‘othering’” (Edwards 2011, 39), by only giving those with the means to access these channels voice both at global and local levels simultaneously, influencing each other in relation to the power of interpretation, acceptance or rejection of disseminated messages (Pal and Dutta 2008; Edwards 2011). The theoretical phenomena in critical modernism of technoscapes form part of communication infrastructure in globalisation, shaping the speed and flow of discourses as well as how discourses will be taken up (Edwards 2011) for health communication as an example.

These online conversation enablers however more often work to highlight important issues of health, can lead to better-informed patients, help ease the barriers of communications for health-care practitioners as well as demystify previously incommunicable aspects of health. They can also increase access for patients in rural areas, far from medical assistance, through e-consultations. In order for the computer-mediated health communication messages to be effective and trustworthy, the communication still needs to be integrated and converge with traditional, local and other forms of media, in addition to the various other communication contexts in which health communication takes place.

Language and messaging in health communication

Health and wellness have always been integral to African cultures. In several African cultures, for instance, greeting a person during any time of the day, centres around asking about the wellness of the other. For example in Sesotho, on greeting another person in the morning, one would ask, “*O robetse hantle?*” literally translated into English meaning, “Did you sleep well?” or “*O tshile hantle?*” meaning “Did you wake up well?” In most African cultures, meeting and greeting is not merely phatic communication, a meaningless social function; rather it intends and is expected by the other, to deliberately solicit responses about the other’s wellbeing such as whether they actually slept and woke up feeling well. Hence, a discussion of language use in health communication as additional to everyday social interaction is relevant.

The (mis)use of language in health messaging across different contexts presents a barrier to communication. Africa has over 2,000 known languages and dialects spoken, with Nigeria alone having 500 languages (Tran 2012). Thus, health promotion organisations, as well as governments are ill-equipped to present tailor-made health messages that accommodate each of these innumerable languages. Yet the majority of rural-based people in Africa lack comprehension of Western languages’ nuance and hidden meaning. The default for most organisations and governments is to communicate in the *lingua francas* of most African countries; English, French, or Portuguese, or target languages for the bigger segments, resulting in linguistic exclusion of minorities in populations. Another setback to possibilities to communicating using indigenous languages is that some of them lack socially acceptable and culturally appropriate terminology. Seidel (1990) found in Uganda that some local languages such as Runyankole lacked socially acceptable terms that healthcare providers could use to demonstrate condom use and sexuality for example.

Translations without Borders Founder, Thicke reveals that in Thange in Eastern Kenya she saw AIDS orphans playing in front of posters with advice on AIDS prevention (Tran 2012). “The posters carried excellent advice, but they were in English, a language that people didn’t understand,” she said, adding that people do not just die of disease, but from a lack of knowledge on how to avoid getting sick. In South Africa, Levin (2014) found that more parents cited language and cultural barriers as a major barrier to health care than structural and socio-economic ones. This was a result of parents not having access to same-language healthcare practitioners. Only 6 percent of the medical interviews were conducted partly or wholly in the patient’s home language.

Use of cryptic health messages

In both mass communication and interpersonal contexts, messages have been communicated cryptically. For public messages, the intention is often achievement of organisational goals, while, at both public and interpersonal levels, communicators, whether organisations or healthcare providers, both attempt to be culturally sensitive by avoiding explicit, possibly taboo words. Researchers argue that many African cultures are conservative and avoid having to directly mention sexually related terms, yet most of them are fundamental to communicating health (Baxen and Breidlid 2009; Kamwendo 2008). In Botswana, a billboard message about HIV infection referred to extra-marital affairs as small houses (Kamwendo 2008), which may be contextually understood among the local people. However, in any given society, there are people who may reside (or even visit), who are not local but may be important target audiences in terms of health-related messages in terms of their behaviour that may miss the high-context meaning of such messages.

Some researchers argue that on the positive side, metaphors enhance health communication by acting as educational tools. Metaphors are also perceived as having the capacity to assist healthcare practitioners such as doctors to simplify terms that would otherwise be difficult for patients to grasp as well as frame and tailor the experience of illness to the patient’s needs (Ervas et al. 2017). It should be noted, too, that many of the healthcare providers, especially doctors, in most of the African countries may be foreign (as is the case of South Africa which has a large component of doctors from Cuba working in rural hospitals) or may not speak the language of the patients.

Still, the outcome of using cryptic language is that it is either too complex for people to understand or is rendered too metaphoric that it loses the essence of what is being communicated. In both cases, the message does not achieve the intended goal. In South Africa, for instance although the intention of loveLife in using cryptic messages as a strategy was to get audiences to talk about HIV/AIDS, messages were misinterpreted. For example, a loveLife message with a slogan, “Prove your love, protect me,” was interpreted by a member of the target audience to mean, “having sex with him means that you will be proving your love for him” (Lubinga et al. 2010, 43). Various researchers found varying levels of abstraction of messages and corresponding misinterpretation of the cryptic messages (Singer 2005; Thomas 2004).

Loss of meaning in translation

In the interpersonal context it is crucial for the healthcare provider to understand the description of the nature of illness by the patient in order to administer the necessary treatment. Van der Berg (2016) argues that successful provider–patient outcomes are based on rapport between both parties, the patient’s control of the dialogue and amount (possibly quality) of information

exchanged. Levin (2014) found that in most of the South African healthcare system consultations are held in patients' second or third languages. In these contexts, nurses are relied on to interpret for doctors who are not competent in English or Afrikaans. The problem is exacerbated in the rural areas where nurses work with Cuban doctors, with no knowledge of Spanish, since from 1996, 460 Cuban doctors have been invited to work in rural hospitals (Govender 2011).

Mass media messages for major campaigns are often crafted in the *lingua franca* of the country and are then translated into indigenous African languages in most countries. The detail is at times lost in translation, because African languages are ambiguous, with one word having several meanings, which is not the case with *lingua francas* for instance.

The ethics of communicating health in Africa

The area of ethics is closely correlated to the high regulatory environment which governs health communication. This includes the explicit outlining of the genuineness of the medication issued or provided by public health systems. The formation of the health communication needs to be focussed on the patient, and should not set blame on patients or place the burden of responsibility solely on them.

Sometimes in health communication messages information is hidden from the public/audiences in order to protect the interests of communicators of health communication messages, whether for profit or to gain favour. Such influential people may often be willing to go against international human rights (IHR) and likely violate patients' human rights. Recently the DA Shadow Member of Executive Committee (MEC) of Health in the Gauteng Provincial Legislature in South Africa, Jack Bloom, was taken to task by media and the public in South Africa over his misuse of absolute numbers with respect to the number of patient deaths at Baragwanath Hospital without proportional context in order to curry political favour. A leading health journalist, Katharine Child, went on to explain publicly the challenge with this and how it was unethical (Twitter 2018).

Often during protests accusations emerge with little regard for ethical consideration of communication, particularly if the risks to patients and the general population are discussed in health communication. The risks often seem to be overlooked in health communication, with the benefits overstated, particularly for global interventions, such as contraception (Lubinga and Sitto 2018), HIV/AIDS and lifestyle diseases such as diabetes.

An example of an unethical study was the "Tuskegee Study of Untreated Syphilis in the Negro Male." This US study, which was started in 1932 and lasted 40 years, involved misinformation and human rights violations. The investigators did not adequately inform participants of the objectives of the study, deliberately misled them into participation and did not inform them that they could choose to drop out (CDC 2017b). The absolute and misleading unethical nature of experimentation during the study of health issues is a practice that is ongoing today on the African continent. In Africa, researchers have been reported as having experimented with live subjects without providing adequate communication to them. Studies involving anti-retroviral therapy (ART) in Uganda, Zimbabwe and Côte d'Ivoire continue to be flagged by international bodies as being unethical (Wemos 2008). These studies remain in existence because pharmaceutical companies in Africa often circumvent processes by exploiting vulnerable populations in developing countries, putting their health and human rights at risk (Shah 2013).

The exclusion of rural, less educated recipients of health communication messages through the use of technical language that is full of medical jargon or that is in a *lingua franca* that is not used in rural areas also blurs the lines of ethics. This is not ethical with respect to the rights of

those patients to be empowered to make informed medical decisions about their health based on what is communicated to them.

Barriers to health communication

Barriers to digital communication and social media exist, although they may in fact positively impact on health communication. Digital and social media are cost-effective; they can reach wider audiences in geographically disparate places almost simultaneously and without additional cost burdens regardless of the number of people reached. However, one of the biggest barriers to accessing information distributed through these media is access to the internet. While global internet access is on the rise, the gap between those who have access and those who do not is widening, which has implications for health communication development.

Developing countries are much further behind with these media because of their underinvestment in infrastructure such as telecommunications infrastructure (Campos 2018). The UN recognises that it is most often vulnerable groups that lack adequate access to use ICTs and the internet, seriously challenging the UN's declaration of access to the internet as a fundamental universal human right (UN News 2015). Coupled with little political will, the digital divide is likely to grow considering that some governments continually use their power to shut off internet access during politically restless times or if online information is considered a threat to power e.g. Zimbabwe, Uganda, Egypt, Libya, Cameroon, Ethiopia (Mukeredzi 2017). The deliberate violation of the UN-declared human right has far reaching consequences, particularly for health, as computer-mediated technologies could be used to improve the delivery of public health communication to remote communities at affordable rates.

Linked to this barrier is that of online security, a growing shadow fed by activities such as hacking, whereby a third party accesses a person's personal information through social media applications (e.g. Facebook's 2018 security breach scandal) and what has been coined by American President Donald Trump as "fake news." A lack of security increases the vulnerability of online users and can have life-threatening consequences with regard to health communication, such as the use of misinformation to make life/death decisions, victimisation of online health activists or even cutting people off from essential health communication.

In terms of health promotion in Africa, governments face budget constraints forcing them to select diseases to prioritise in terms of communication. Prioritisation appears to be driven by the burden of the disease and the measure of its effects on society. Priority in communication is also made on the basis of whether messages will be effective because of the scarcity of resources. As a result, HIV/AIDS has taken the bulk of the resources and has been the subject of several campaigns. However, diseases such as cancer (apart from breast cancer for women and prostate cancer for men) continue to prevail or seem to be on the increase, and then there are other diseases whose target populations are ignorant of the risks, such as with male breast cancer (Motloutsi and Lubinga 2017). Would interventionists consider combining promotion of similar diseases in health messages communicated to target audiences such as female and male breast cancer, rather than focusing on the female version only? Prioritisation of diseases and focussed efforts have resulted in what MSF has termed as the exclusion of millions of Western and Central African people from global HIV efforts (MSF 2016).

In sum, this chapter has mapped key organisational players of healthcare communication in Africa. It has critiqued theories commonly used for researching health in Africa, whose balance is tipped in favour of dominant Western approaches despite criticism that they are ill-fit for African contexts. It presented a case study underscoring the important role of communication

in concerted efforts to fight the Ebola virus in some West African countries. It examined the important role of civil society or activist organisations as well as online health activism. It highlighted impediments to languaging in health communication messages, ethics in healthcare communication, and barriers to such communication.

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