

4 Developing a targeted behavioural change communication strategy for a linguistically and culturally diverse community

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Introduction

Social and behavioural change communication (SBCC) as a domain in health communication is increasingly being recognised as a valuable tool for modifying lifestyles which pose a threat to people's well-being, and for facilitating improvements in health (Canavati et al., 2016; Hodinot et al., 2017). It becomes particularly valuable in low-middle income countries such as South Africa, where the burden of disease, particularly HIV/ Aids continues to be concerning as noted in recent health surveys such as the South African National HIV Survey V and the South African National Health and Nutrition Examination Survey.

Effective management of disease requires that a patient be adequately informed not only about the nature of the health condition but also about lifestyle and behavioural changes that are commensurate with managing the condition. SBCC initiatives therefore play a vital role in facilitating patient information, thus being one of the enabling factors for patient lifestyle and behavioural changes. Although there has been a plethora of SBCC initiatives, especially for HIV/Aids messaging in South Africa, there has been minimal awareness, among communication developers of the value of involving target communities in the

development of these initiatives. There are even fewer documented efforts to base these initiatives on sound theoretical grounding and empirical research that document the needs of the target communities.

This chapter highlights the value of community participation in developing a health communication strategy, and the value of sound theoretical grounding. It unpacks some of the pertinent theories that can inform a health communication strategy. These include the meta-theory of health communication (Kincaid et al., 2012); the health belief model developed by social psychologists the US Public Health Service in the 1950s to explain the relationship between people's health behaviour and perceived risk (Kibler et al., 2018); and theories of communication ecology which originated in the 1970s to describe communication environments and their impact on people (Foth & Hearn, 2007; Scolari, 2012). This chapter also discusses the role of culture in developing and disseminating health messaging (Brincat, 2012), and the importance of choice of communication platform (Felix et al., 2015; Lima et al., 2018) as we argue that these are some of the factors that account for the effectiveness of any SBCC initiative. Lastly, the chapter proposes a framework for the inclusion of the target community in developing a health communication strategy.

The value of using theory in developing communication strategies

Global health organisations have developed strategic foci on health communication, alluding to its significance in promoting health changes in individuals and communities. The Centers for Disease Control and Prevention (CDC) as a leading health organisation is an example. It defines health communication as 'the study and use of communication strategies to inform and influence individual decisions that enhance health' (CDC, 2019: n.p.). This resonates with Schiavio et al.'s (2014: 77) definition of health communication as a 'multifaceted and multidisciplinary field of research, theory, and practice concerned with reaching

different populations and groups to exchange health-related information, in order to influence, engage, [and] empower’.

Subsumed in these definitions are multiple ways in which health communication can influence behaviour, namely: (1) creating awareness by providing the target population with information about the health problem, healthcare services and specific actions that people can take to manage or react to the problem (Krige, 2012); (2) improving people’s attitudes by emphasising the positive benefits of the behaviour being demonstrated as well as the negative outcomes that may arise if the behaviour is not practiced (see Mutinta, 2012); and (3) connecting and encouraging people to access services by modelling what to expect and how to act when they arrive (see Kunda & Tomaselli, 2009).

These key principles of health communication have made it a potentially useful tool in fighting the concerning prevalence of HIV/Aids, and the continued persistence of non-adherence to antiretroviral medication. Along with this relevance, there has been increasing acknowledgement of the need to ground health communication (and thus SBCC initiatives) on sound theoretical frameworks in order to enhance their effectiveness (Airhihenbuwa & Obregon, 2000). The available theoretical work on health communication is rooted in disciplines such as social psychology, behavioural sciences and communication science. When used as a basis for a strategy, theoretical frameworks may help in predicting the relationship between interventions and behaviour. For example, according to Laranjo (2016), the health belief model posits that there is a relationship between people’s likelihood to take preventative action against a health issue and their perceptions of the seriousness of the health threat of that health problem. Grounding a communication intervention in such a theoretical framework therefore helps to unpack how, when and why people would potentially change their behaviour and thus help inform the design of interventions, as well as the appropriate time and context of an intervention. Since they have been grounded on past research, theoretical frameworks can inform the specific actions that a communication intervention can take to influence

behaviour changes, and help to predict factors that could potentially hinder or promote these changes. A theoretical framework is therefore a valuable tool in shaping the conceptualisation of an effective communication intervention. The following are some of the pertinent theories that can be drawn on in developing a health communication strategy.

Theories rooted in social psychology

Health communication theoretical frameworks rooted in social psychology draw from health behaviour theory concepts such as stages of change from the trans-theoretical model, self-efficacy from social-cognitive theory, perceived susceptibility from the health belief model, and attitudes, social norms, and behavioural intentions from the theory of reasoned action and planned behaviour (Lee et al., 2015). These concepts are useful in the development of an intervention, particularly a communication one, in that they inform the tailoring that could determine the success of an intervention as noted in Lustria et al. (2013).

The meta-theory of healthcare communication posits that the effectiveness of a health communication intervention is a result of the successful interaction between resources and psycho-social factors that would influence behaviour change (Kincaid et al., 2012). A communication strategy that infuses resources such as promotion, dialogue and advocacy among others, with a set of ideational (psycho-social) factors such as cognitive elements (e.g. beliefs), emotional factors like self-efficacy, and social elements (e.g. interpersonal communication) has a higher potential to influence behaviour change. This potential is increased if the strategy also takes into account other factors such as the socio-economic, political and cultural environment: 'Individuals and their immediate social relationships are dependent on the larger structural and environmental systems: gender, power, culture, community, organisation, political and economic environments' (Manoff Group, 2016: 4). A strategy that has taken into account this comprehensive ecosystem has a potential to influence

self-efficacy which, in turn, could positively influence all aspects of human behaviour, including health-related behaviour (Bandura, 2006). When ideational factors that are relevant to understanding a health problem and the need for changed behaviours are addressed, communication programmes are more likely to have a positive impact on health behaviours and ultimately on positive outcomes.

Other social psychology theories tap on the power of role-modelling to change behaviour, and some communication programmes apply these role modelling theories to encourage audiences to model positive behaviours that are presented through the communication intervention, as noted in Bandura (2001). Social cognitive theory (SCT), a cognitive formulation of the social learning theory, is one such theory which asserts that audiences identify with characters who demonstrate behaviour that engages with their emotions, facilitates mental rehearsal and ultimately role-modelling of the new behaviour. SCT, as articulated by Bandura (1986; 2001; 2006) explains human behaviour using a three-way model which presupposes a continuous interaction and reciprocated influence between personal factors, environmental influences and behaviour. The theory is premised on the fact that people learn not only through their own experiences but also by observing the actions of others and the results of those actions. In this way people are more inclined to model characters who demonstrate behaviour that engages with their emotions and ultimately emulate those role models and change into new behaviours (Govender et al., 2013). This role modelling of the new behaviours could ultimately result in encouraging self-efficacy and thus behaviour change (Maloney et al., 2011).

The use of role-model stories is increasingly becoming appropriate for adaptation in the development of health communication interventions. This approach is primarily based on social learning-cognitive theory (Bandura, 1986) wherein role-model stories combine experiences of a 'model' individual in a narrative format that incorporates cultural values, language and local relevancy for targeted communities. Role-model stories share information in

‘a non-threatening manner by fostering identification with story characters and experiences, engaging recipients with storyline messages, appealing to personal values and interests, reducing counterarguments against key messages, and improving information retention’ (Hinyard & Kreuter, 2006, cited in Berkley-Patton, 2009: 2–3).

Theories informing message design

Other theories inform the process of message design. The communicative ecologies theory is one such theory which asserts that an effective communication strategy needs to be based on evidence of available information resources and practices in a community for which it is intended. The design of a communication strategy can be informed by conducting a communication ecology assessment of the targeted community, or one that is similar to it. The concept of communicative ecology defines a number of mediated and unmediated forms of communication existing in a community (Tacchi et al., 2007).

Foth and Hearn (2007) conceive communicative ecology as having three layers: (1) a technological layer which consists of technologies and connecting media that enable communication and interaction; (2) a discursive layer which is the content of communication available in the community; and (3) a social layer which consists of people and social modes of organising those people. These three layers converge in distinct and localised ‘communicative ecologies’ (Foth & Hearn, 2007).

The communicative ecology does not ignore the context of the community in terms of who has access to certain resources, power relations and the local economy as well as the socio-economic factors that have a bearing on message access and interpretation. These are all important factors when attempting to understand why certain mediums are used in specific spaces and the personal role that the media plays in people’s lives (Tacchi et al., 2007).

The technological layer of communication

In the South African context, the technological layer of communication denotes the mass media (print and broadcast media) and new media technologies (internet and mobile phones) available in communities. The mass media in South Africa, as a commercial enterprise, is generally speaking highly corporate and commercialised. However, for communities where television broadcast is not accessible, community radio plays an important role as an alternative source of information. In rural resource-limited areas community radio is less costly and enables isolated communities to voice their own concerns, while also being informed. For example, ordinary citizens discuss on air issues that are central to them, such as gender relations and combating HIV/Aids, and hence are informative to listeners (Madamombe, 2005).

In terms of new media, Mukund et al. (2010) show that South Africa has one of the largest cell phone coverage in the world, and people use cell phones as a daily communicative tool. Cell-phone containers operated in spaza shops and individual homes are widespread across many townships and rural areas (see Skuse & Cousins, 2008). Because of their accessibility, they are an ideal resource for health communication. Recent statistics on digital population in South Africa show that South Africa has 31.18 million internet users of which 28.99 million are mobile internet users (Statista, 2019). Cell phones are therefore an ideal resource for health communication, and present an opportunity for a wider reach for antiretroviral adherence communication programmes that use cell phones as a communication tool.

The social layer of communication

The social layer of the communicative ecology consisting of community organisations, rallies, community meetings, social clubs (stokvels) and churches provides useful and alternative communicative spaces where social networks are forged and strengthened. These are forms of unmediated communication: face-to-face/interpersonal communication not done through any channel of media, as opposed to mediated communication which is

done through different form of media. The social communication spaces play important roles in broader community struggles for social and economic development (Chiumbu, 2010; Wilkinson, 2013). These kinds of social networks that are already available in most South African grassroots communities can be tapped into as platforms for communicating HIV treatment adherence messages. Their value is that they already have strong roots in the community and have insider perspectives of adherence issues in their locality. Such community networks have already been used successfully in other countries such as Malawi (Zachariah et al., 2006) and South Africa (Wilkinson, 2013).

The extended parallel process model (EPPM) positions message design at the centre of potential responses by the target community. The theory posits that if messages are framed as threats, an individual's response involves two distinct cognitive appraisals (Witte, 1992). The first appraisal relates to the degree to which the message is perceived as threatening (i.e. how susceptible an individual believes they are to the threat and how severe the consequences would be should the threat occur). If the individual perceives that they are personally vulnerable and the threat is severe, a second appraisal, coping appraisal, occurs whereby the individual considers whether the message provides effective and useful strategies (i.e. 'response efficacy'), and whether they believe that they possess the ability to enact such strategies (i.e. 'message self-efficacy') to help avoid/reduce the threat (Witte, 1992, 1994). In other words, the extent to which an individual is fearful in response to the message's threat (as a result of the first appraisal), determines whether they are motivated to continue processing the message. In turn, the coping appraisal determines the nature of an individual's response to a message and whether they initiate adaptive (danger control) or maladaptive (fear control) processes which correspond to message acceptance and message rejection respectively (Witte, 1992, 1994). EPPM assigns a more significant role to the emotion of fear than some of the EPPM's theoretical predecessors (Witte, 1992; Witte & Allen, 2000). In the EPPM, if a threat is considered relevant and severe, the emotion of fear is

posited to ensure ongoing processing of the message and efficacy will determine whether an individual seeks to control the threat (danger control) or to control the fear (fear control) (Witte, 1992; Witte & Allen, 2000). Thus, the emotion of fear may be considered important for individuals' attention and functioning to ensure ongoing processing.

The effectiveness of any communication strategy therefore requires in-depth understanding of the targeted population. This understanding can only be fully achieved if the intended population is actively involved, providing insider knowledge of the dynamics of their own communities, and being collaborators in what can work in their own context.

The role of culture in shaping peoples' understanding of health messaging in different contexts

As health communication continues to be seen as important and the need for communication contextualisation is increasingly understood, there has evolved a consensus that culture also has to be taken into account in designing messaging. This is in acknowledgement of culture as a factor that can influence health and health behaviours (Tseng, 2001). In-depth understanding of the cultural characteristics and practices of a given group allows communication interventions to be customised to meet the needs of people affected or who are at risk. Spencer-Oatey (2000) conceptualises culture as set of attitudes, beliefs, behavioural conventions and basic assumptions and values that are shared by a group of people, and that influence each member's behaviour and each member's interpretations of the 'meaning' of other people's behaviour. This is consistent with Samovar et al.'s (2012) definition of culture as the rules for living and functioning in a certain society. These rules determine and influence how members of a community generally behave, and, as a consequence, community action and reaction to messaging is oriented by culturally mediated beliefs about what is real and what is good.

The calls for the incorporation of culture in designing health promotion messaging (Airhihenbuwa, 1995) were made in

cognizance of the fact that different cultures differ in their descriptions, conceptualisations and experiences of health problems, their causes, perceptions of how to react to the problem. When these differences are not well managed in designing messages, misunderstandings are likely to occur and the health communication strategy is likely to become ineffective in influencing the necessary behaviour changes.

Culturally sensitive and culture-centred health communication approaches

Efforts to ground health communication and health promotion on culture have resulted in two research-based approaches, namely, the cultural sensitivity approach and the culture-centred approach (Dutta, 2007). Betsch et al. (2017) define culture-sensitive health communication as an approach that makes deliberate efforts to engage in evidence-informed adaptation of health communication to the recipients' cultural background with an aim of enhancing the persuasiveness and thus effectiveness of messages in health promotion. The adaptation can be in the form of incorporating culturally appropriate and sensitive terminology to a health communication strategy (Dickerson et al., 2018). This is expected to lead to self-efficacy and improves recipient's preparedness for health medical decision-making. The goal of the cultural sensitivity approach is therefore to ensure that message content and message framing is sensitive to the culture, and that culturally appropriate terminologies and language forms are used. This approach has, however, been criticised for often being superficial and for sometimes tailoring the message content to an already available approach that does not fully respond to the cultural spectrum of a target audience.

While culturally sensitive approaches focus more on adaptation, culture-centred approaches harness culture-specific knowledges of the target communities and employ co-creation and co-development of communication strategies with the communities. Culture-centredness embraces communication strategies that utilise indigenous history, language and values as a basis. In this way

the intervention helps the target communities to ‘both decolonise and reclaim their cultural beliefs, practices, and aspirations that promote health and well-being’ (Dickerson et al., 2018). Adding the principles of co-creation to this culturally-centred knowledge facilitates the sustainability of a health community strategy. This is because there is a sense of inclusion and ownership by the targeted population from the initial stages of development. The approach recognises the value of using community agency, strengths, power and language as a foundation to sustainability and a facilitator of health behavioural changes (Belone et al., 2016, 2017; Dickerson et al., 2018; Dutta, 2007). Basing a communication strategy on the co-creation with a community and on local cultural knowledge, practices and aspirations can improve their ultimate efficacy.

There is a body of literature that sees the two approaches as alternatives (e.g. Dutta, 2007; Okamoto et al., 2014). However, there is also a large body of literature that sees them as a continuum (e.g. Dickerson et al., 2018). We argue that both approaches could yield positive results if they are used to complement one another. Each one affords the process of developing a communication strategy that taps into culture at different spheres to produce a strategy richly informed by in-depth understanding of the target community.

Empirical examples of successful culturally-oriented health communication in the Global South: a specific focus on HIV/Aids

Since HIV/Aids continues to be one of the global health threats, most communication campaigns have targeted this area. Most of the campaigns have developed communication strategies and interventions which often take community-based approaches and capitalise on co-creation with local communities to enhance effectiveness. They therefore provide valuable insights into the value of being aware of, and incorporating culture in developing a communication intervention.

Some of these successful interventions, based on co-creation with local communities, have been reported in countries such as

Thailand (Nelson et al., 1996), Ethiopia and Uganda (Gusdal et al., 2011). In Uganda and Ethiopia, an adherence to an antiretroviral (ART) programme was implemented in both countries for a HIV-infected cohort. Part of the programme was to involve peer counsellors as facilitators of adherence. They acted as role models, and were involved in the development and dissemination of awareness messaging in face-to-face interactions. Their involvement in the process ensured that culturally appropriate messages were developed and disseminated in local languages through culturally sensitive interactive processes. Since they had insider knowledge of the cultural dynamics of the community, their involvement provided patients with an opportunity to individually talk to someone who was also living with HIV, who had a positive and life-affirming attitude about their situation, and were willing to share personal stories of hope when educating and counselling their patients. The programme had very positive effects on ART adherence and its success was attributed to the involvement of community members (Gusdal et al., 2011).

In South Africa, we draw from two examples both of which involved the involvement of local community members to disseminate ART adherence education. Peltzer et al. (2012) reports on the effectiveness of an ART adherence intervention programme implemented in a hospital in KwaZulu-Natal, involving information-sharing group sessions facilitated by a trained lay health-worker from the local community. The involvement of this facilitator brought with it communication in a local language and in-depth knowledge and sensitivity to the culture of the community. Wilkinson (2013) reports on the successes of the adherence club intervention in Khayelitsha, which employed the strategy of using group meetings facilitated by a local facilitator who provided adherence education as part of the intervention package. The common thread in the two interventions is dissemination of health communication through a local facilitator, thereby tapping on the local knowledge of the cultural dynamics.

In Cambodia, Manavati et al. (2016) report on a malaria-related intervention implemented in cognizance of, among others, the

rising concerns about the spread of drug resistance. A conflation of intense social and behavioural change communication (SBCC) activities was implemented by different organisations working in areas identified for malaria containment. This intervention package included new SBCC messages to inform and create awareness among the public. The SBCC intervention package was as follows (Canavati et al., 2016):

- Dissemination of media products for broadcasting on radio and television;
- Working with village health volunteers to communicate messages to encourage preventive and positive health-seeking behaviour in communities, build the capacity of health-centre staff and improve the utilisation of the public health system for malaria diagnosis and treatment; and
- Working with village malaria workers and mobile malaria workers, who are community members, to encourage preventive and positive health-seeking behaviour in communities.

In that way, the intervention involved community members to do health communication in their own communities and in local languages. The shared community membership subsumed with it in-depth knowledge of the psycho-social factors that surround the health issue in the community, and the relevant cultural considerations to be made in communicating to these communities. The intervention's successes of positive improvements in both attitudes and behaviours among the population, and the increase in people seeking treatment for fever, can be attributed to the involvement of insiders to the community.

These examples highlight the value of the involvement of people who understand the culture and language of the community in health communication activities. These people fully understand the cultural aspects of the disease and how culture has determined the way in which people in that community describe and react to the disease. They also fully understand the local language and are conversant with cultural sensitivities related to any of these

diseases. Their communication is therefore culturally appropriate and they know how to make the content both culturally appropriate and sensitive. An effective health communication strategy should therefore consider the locally available package of knowledge, resources and skills and use these resources.

Choice of communication platform as an enabler for the effectiveness of a health communication strategy

The success of a health communication strategy also depends on the choice of communication platform and the extent to which the platform is accessible to the target community. Given the changing patterns in communication, marked by a shift from traditional ways of communication to digital platforms, there has also been a transition to digital platforms in health communication. In this section we discuss some of these novel platforms in health communication and what makes each of them successful.

MHealth Interventions

The use of mobile phones in health intervention programmes has increasingly gained momentum over the years. These platforms, collectively called 'mHealth', have afforded communication organisations wider reach given the penetration of mobile phones even to remote areas. The World Health Organization (2011) in its report 'mHealth: New horizons for health through mobile technologies' identifies several categories of mHealth such as health call centres, mobile telemedicine, appointment reminders, community mobilisation and health promotion, mobile patient records, information access, patient monitoring, health surveys and data collection, surveillance, health awareness raising, and decision support systems. mHealth, especially in the area of HIV/Aids is growing in Africa. According to Klasnja and Pratt (2012), mobile technology is a particularly attractive tool for delivering health interventions, due to: (1) its widespread adoption and potential for powerful technical capabilities; (2) the tendency to

carry mobile phones everywhere; (3) people's emotional attachment to phones; and (4) the context-awareness features of mobile phones that allow for personalisation. In particular, texting is an effective way to educate and support under-served and diverse populations due to its mass reach and relatively low cost (Fjeldsoe et al., 2009). For health purposes, texting can be used to (1) enhance health service provision (i.e. appointment reminders, vaccination reminders); (2) distribute mass health education messages (i.e. disease outbreaks); (3) encourage better disease self-management practices; and (4) deliver personalised health promotion interventions (Fjeldsoe et al., 2012). Studies elsewhere have also found that mobile phones have advantages when used in health programmes for the youth, as young people in general are responsive to and excited about using new technologies.

For a successful mHealth platform in South Africa, we draw on the example of the MomConnect platform, a multi-faceted programme aimed at promoting demand for maternal health services as well as improving the supply and quality of those services to expectant mothers. The programme includes stage-based health messages sent by SMS to expectant mothers, a text-based help desk that provides answers to pressing questions, a library of health information accessed via a USSD menu, among others. An evaluation of the programme by Skinner et al. (2018) showed that the target community was happy with the service, citing valuable content, accessible medium, and ability to save messages for further empowering others as the strengths of the platform. In that way the platform was effective and it met the target population's needs.

A second example is the Biolink platform developed for implementation in KwaZulu-Natal with the aim of linking people living with HIV with care (Comulada et al., 2018). Patient home visitation data is stored in an Android smartphone application and is accessible to the research team and to clinic staff. When clinic staff identify someone who is infected, who is not linked to care and who does not collect prescription refills within a specified time, SMS alerts are sent to field staff mobile

phones so that they can follow-up with their assigned patient to facilitate linkage and/or medication adherence. Such use of cell phones as a platform was reportedly successful, due to the high cell phone coverage and the cost effectiveness of the platform. This resonates with the observation that SMS is a favoured approach in South Africa and low- and middle-income countries due to its low cost and flexibility across mobile systems relative to other mHealth tools, such as mobile applications (Lester et al., 2010; Mukund & Murray, 2010).

Beyond South Africa, an example of a programme that used SMS messages is the Kenya Weltel programme implemented from 2007 to 2009 to improve adherence to ART (Van der Kop et al., 2012). The intervention involved sending weekly messages to patients inquiring how they were doing, and participants were required to respond either that they were well or that there was a problem. In a randomised controlled trial, Van der Kop et al. (2012) show that weekly text messages led to improved ART adherence and viral load suppression among those initiating ART. The intervention enabled frequent communication between clinicians and patients, and many patients valued the service for the support it provided and for its cost-effectiveness and ease of accessibility.

Social media

Beyond text messaging, the use of social media in health communication interventions is being adopted, although the current body of knowledge on this is limited. Social media is increasingly being considered as an innovative tool in SBCC because of its capacity to target and reach diverse audiences since it is not limited by space or time.

Social media is an inexpensive, effective method for delivering public health messages. Based on the understanding that SBCC is not merely the transmission of health information to passive audiences, the multi-directional interactivity in social media offers an unmatched advantage (Adams, 2010; Taylor, 2012). Not

only is social media being used in searching for health information, clients now get involved directly in managing their health conditions through the use of social media (Campbell & Craig, 2014, cited in Adewuyi & Adefemi, 2016). Although social media is increasingly being used by public health departments in developed countries, it is not yet clear how best to capitalise on social media for raising awareness and, ultimately, triggering behavioural change (Gough et al., 2017). In Africa, the use of social media in health communication campaigns is still very low. There is room for expansion despite digital inequality or divide, to creatively use social media for communication campaigns in the HIV sector. Research shows that mobile social media use in Africa is increasing year by year (Gough et al., 2017).

These technology-based communications highlight the need to be innovative and to capitalise on new and accessible technologies when developing a communication strategy. This implies that prior to developing a strategy there is a need to conduct an in-depth needs assessment and a communication ecology to identify platforms that will be acceptable and accessible for the target community. There is also a need to gain insight into what resources are already available and how they can be harnessed for use in the community.

Conclusion

The discussion in this chapter shows that the effectiveness of a health communication strategy is a result of multiple factors all of which entail a deep understanding of the target community by communication developers and implementers. The theories discussed illuminate the value of understanding the cognitive behaviours and decision-making practices of an audience before developing a communication strategy. The theories also underscore the importance of understanding psycho-social behaviours such as attitudes towards a particular health problem, in order to predict potential reactions to messaging. This knowledge is instrumental in informing message content and delivery.

The chapter also highlights the need to understand and incorporate culture in designing a health communication strategy. This entails the deliberate adaptation of messaging to culture and deliberate co-creation and co-development with locals as a resource which has insider knowledge of the cultural dynamics of a given community. When message content has been developed, dissemination also requires tapping into the local community and harnessing their own 'knowledges' in conveying the messages in order to enhance acceptability of the messages and facilitate reaching the desired health behaviour changes.

Ultimately, all these point to a need for the involvement of the target community in all aspects of development and dissemination of health communication strategy. In particular, their involvement should go beyond the channel of communication and delve into their participation as co-producers in order to ensure the sustainability of the strategy. We argue that the development of a health communication strategy should not take the 'us for them' approach where developers own all the processes and use locals for dissemination, but an 'us with them, for them approach' emphasising the principle of co-creation of knowledge.

Framework for community inclusion in developing a strategy

Given the obvious need to involve the target community, we propose the following as a framework for the inclusion of the target population. The framework is an integration of insights from this paper and principles from Netto et al. (2010). The proposed framework involves the following steps:

- Conducting a needs assessment to establish the health communication needs of a community, and identifying the already available communication platforms and current practices. This should be done in collaboration with the target community to get community-relevant information. Using the resources is likely to increase intervention accessibility.

- In developing the strategy, involve the segments of the target population throughout the process to ensure cultural appropriateness of the content a delivery plan. Harness the knowledge they already have and incorporate such knowledge in the strategy. There is also a need to harness the significance of cultural and religious authorities due to the influence they have on communities. The involvement of this cadre of society and the use of already locally recognisable knowledge has the potential of being easily accepted and likely to influence the desired change.
- In choosing the platforms of communication, it is valuable to consider the use of platforms that already have a wide reach in the community. This does not only facilitate positive user experiences, but also facilitates accessibility, which will increase the reach of the health messaging and potentially have a positive impact. Dissemination should also be by locals who speak local languages and are able to respond to questions in the language of the community and in culturally appropriate ways.

With this proposed involvement of the target audience in all facets of the development of a health communication strategy, we argue that there is increased potential for efficacy and sustainability.

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