

# Towards a Homophilous Communication of Messages on Healthy Eating Habits to the Men in Rural Villages of Botswana

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**Abstract** Spontaneous discussions and interactions with the men in the villages revealed that many of them had developed gouty arthritis. The discussions also revealed that some of them had been advised against eating too much red meat by the local nurses. Despite the advice from the local nurses, red meat remained a popular dish with the men. This prompted the question: why do the men in the villages not embrace the advice to give up unhealthy eating habits? What means of communication are used to communicate messages about healthy eating to the men? To gather information on these questions, a semi-structured and unstructured interview methods were used. The results showed that the village men had a profound deficiency in the knowledge about foods. Also, the results showed that an effort to embrace and incorporate the cultural expressions of the villagers into the communication processes was made by the local nurses. It is recommended that frequent and intensified health campaigns be organized and that health promotion officials should adopt and utilize the Diffusion of Innovation Theory in the health campaigns on eating healthy foods that target the men in the villages.

**Keywords** Communication, Messages, Healthy Foods, Village Men, Cultural Expressions

## 1. Introduction

The adage that "we are what we eat" seems to hold true

for the Botswana men in remote rural areas. Remote rural areas in Botswana are a replica of what Seru calls "low resourced and closed communities" [1]. They are principally the small scale low socio-economic settlements. As attested to by Palescha, Chang and McGrath [2], remote village communities generally face a challenge of eating healthily and sustainably [2]. Because of this challenge, they by comparison to urban and peri-urban settlements, experience greater risks of chronic diseases and inequality in access to health information [1,2].

Through informal discussions, observations and listening to some of the men in the selected remote villages during festivities and funerals, it was established that many of them had developed gouty arthritis on account of eating unhealthy diet, specifically, on account of eating too much red meat. Many of them intimated to have been advised by the local nurses to cut down on meat consumption. Notwithstanding such plausible advice, red meat remains one of the most popular dishes with the men in rural areas. It is always cooked in abundance whenever there are some festivities and funerals. The meat at such events is cooked by the men in large three-legged pots in open fires and is pounded to give it a soft and rich taste.

An observation on how the meat at such events is cooked revealed that fats are not removed to make the meat lean, a practice that attests to the unhealthy cooking and eating habits of the men. While it might seem unproblematic to eat large amounts of fatty meat at special events like weddings and parties, the real problem that was observed

was the frequent intake of meat even on ordinary occasions. In every pub in the villages, cooked cheap fatty goats/cattle/sheep intestines and shredded and pounded meat were sold, thus making the men eat meat on most days.

It was not surprising that the men demonstrated poor and unhealthy cooking habits. The Botswana traditional culture “disallows” men, particularly married men, from cooking or selecting food. Also, as young boys mature, they progressively become socialized into this practice and they generally leave the cooking and food selection to girls who in most cases help their mothers with the cooking. Even though modernisation has engendered a derogation of this practice, especially in urban areas, in rural areas there are still a lot of men who are still clinging to this old practice.

The continual consumption of meat in large quantities by the men despite having been advised to desist from the habit prompted the inception of this study. While it is a universal truth that the knowledge of the repercussions of eating unhealthy food is never a deterrent, it was concerning that even the men who had already developed gouty arthritis were persistent in their consumption of the meat. This begged the questions: Why do the men in the villages not embrace the idea that they should give up on unhealthy eating habits? What channel(s) of communication are messages about healthy eating communicated to the men?

As confirmed by Lee, Kim and Jung, many of the men in rural villages are illiterate and poor, and they mainly acquire and share information through interpersonal means of communication [3]. Thus, given the problems that usually occur when people from different social backgrounds communicate, there was a speculation that the socio-cultural differences between the men and the local nurses could serve as major hindrances to the successful dissemination of messages about healthy eating habits. Because of their relatively higher social and economic status and academic credentials, there was a speculation that the local nurses could be disseminating messages about healthy eating from the ambit and assumptions of their own sub-cultures, as well as their relative and apparent expert and elitist positions with little regard for rural men’s unique characteristics, lifestyles and ways through which they share and communicate information. In light of this, this study adopted the hypothesis that: the resistance by the men to change their unhealthy eating habits might be caused by local nurses’ use of communication channels that are not aligned to the remote village men’s nature, values, and communication practices.

This study recognizes the need for effective communication when promoting and implementing government initiatives such as a health communication campaign. It uses the dissemination of information about healthy eating habits as a case study. The findings of this study, and its associated recommendations, would therefore be applicable to the implementation of any communication initiative in any communities that are similar to remote villages in Botswana. The lessons on the

adverse consequences of not taking cognizance of the socio-economic and political contexts of the people for whom information is targeted can be learnt from the South African and Nigerian experiences. In both instances, governments acted as if they held a monopoly over the knowledge on how information about policies and programmes intended to improve the living conditions of the people at the margins could be communicated.

In Nigeria, a noble and well-conceived “Health for All” programme failed to yield desired results because of what Olutimayin called non-existent effective communication channels among health facilities, districts and community members [4]. In simple terms, the programme failed because the communication between decision makers in urban offices and implementers in rural areas was ineffective and needed attention. In South Africa, because of a communication gap between municipalities and communities in rural areas, the goals of a Rural Development and Poverty Alleviation programme were not realised [5]. The same report asserts that a great number of violent protests in some parts of South Africa occurred because of the lack of effective communication between the local sphere of government and the communities under its jurisdiction [5].

## 2. Health Communication

The field of Health Communication emphasizes the use of channels of communication that can reach everyone in target communities with health promotion messages [6]. Effective dissemination of health messages depends chiefly on a health promoter’s awareness and use of communication channels that would reach everyone in target communities [6]. Even health communication programmes that have been methodically planned may result in limited impact if some sectors of communities are not reached by the messages [6,7]. This indicates that it is essential for health promoters to determine communication channels that can reach different sectors of communities they seek to reach with health promotion information. Using channels of communication with disproportionate reach and impact would not be fair and balanced [7]. To ensure effective delivery of health messages and being able to reach all sectors of target audiences, the field of health communication is rooted in several models and theories. Among them is the Diffusion of Innovation model within which this study is embedded [8,9,10,11,12].

In the Diffusion of Innovation model, an innovation is defined as an idea that is new to an adopter, while diffusion entails communicating the idea through certain channels among members of the social group [13,14]. If an idea is perceived as new by members of a social group, then it is considered as an innovation [13,15]. Put differently, the Diffusion of Innovation means ways through which new ideas are communicated to target audiences. The diffusion process is an interaction between people where one person

communicates a new idea to another person or a group of people in a social system [14]. Four basic components of the diffusion process are distinguished: a new idea, a person who has the knowledge about the new idea, another person or group of people who are not yet aware of the new idea, and a communication channel that connects the two individuals [14].

The communication channel that is used to communicate a new idea is very important in determining whether or not the new idea is adopted by the other person or persons [14]. This therefore means that the choice of the channel that is used by the communicator should be made in light of the communication act and the nature of the person or persons to whom the message is sent. It is in view of this pronouncement that this study sought to unearth whether messages about healthy eating were aligned with the nature, values and communication practices of the men in remote rural areas.

Communities are most likely to embrace new ideas if they find that they bring them clear advantages, are linked with their values and norms, and they enjoy access to channels that carry those ideas [15,7]. Even though mass media channels are often the quickest in terms of transmitting messages, they are not as effective as interpersonal channels in terms of persuasion, especially when interpersonal channels are linking two or more individuals who are similar [6]. The effectiveness of interpersonal channels of communication over mass media channels is emphasized [16]. Despite the suggestion that health promoting mass media campaigns can increase the likelihood of positive behaviour change, questions regarding which features of a particular campaign make it effective in comparison to others, and which processes within individuals make success more likely to be achieved, remain unanswered [16].

The decision to adopt or not to adopt an innovation is a mental process that involves passing first from the knowledge about the innovation to a decision to adopt or reject it and to confirmation of the decision [14]. The adoption of a new idea is determined through a five-stage decision-making process which covers: knowledge, persuasion, decision, implementation and confirmation [6]. The knowledge stage, also called the awareness stage, enables individuals to become aware of the innovation and gain an understanding of how it works and what advantages it has. In the persuasion stage, also called the interest stage, individuals form an attitude towards the innovation and seek more information about it if they feel it is relevant to their needs and is commensurate with their belief systems [14,6]. The decision stage involves engaging in activities that would lead to the adoption or rejection of the new idea, while in the implementation stage individuals begin to use the idea assuming they adopted it in the decision stage. The confirmation stage involves seeking reinforcement of the innovation decision to reduce any misgivings adopters may have about the innovation [14,6].

The sentiment that interpersonal channels of

communication are more effective than mass media channels suggests that the effectiveness of the diffusion of information to remote villagers would depend entirely on the utilization of interactive channels of communication that enhance homophilous communication [6]. In any case, the introductory section of this paper shows that the most common form of communication in remote rural villages is interpersonal communication. Homophily is the degree to which interacting individuals have similar social attributes such as beliefs, education, language, and social status [13]. When homophilous communication is used to propagate the dissemination of healthy messages, new ideas are likely to have a greater effect in terms of knowledge gain, attitude formation and change, and overt behaviour change [15,14]. Premised on these theoretical pronouncements, this study aimed to find out whether the nurses in the villages grounded their communication of messages about healthy eating habits in the discursive and cultural practices of the men and the flows of interpersonal communication that operated in the villages.

### 3. Materials and Methods

Based on a qualitative methodological emphasis, this study adopted a case study approach. Using the case study of healthy eating habits information, this study suggests that the communication processes of the nurses need to be embedded within the villagers' socio-cultural and political contexts. In other words, the study is anchored on taking full cognizance of the remote men's socio-cultural contexts when disseminating information about healthy eating habits to them. Thus, an investigation into the communication processes of the local nurses was made using semi-structured and unstructured interviewing. The choice of these two methods was influenced by the realization that they would enable a deeper understanding of the wider social, cultural and political contexts of the men, and how health information messages should be communicated to them. In a nutshell, this section details the pragmatic application of these two methods to uncover the communication processes of the local nurses, the men's existing knowledge about healthy eating habits, and the subsequent analysis of data.

#### 3.1. Semi-Structured Interview

To confirm or refute the speculation that local nurses could be disseminating information on healthy eating from the assumption and ambit of their sub-culture, the following questions were asked: What means and channels of communication do you use to communicate messages about healthy eating habits to remote village? How do you ensure that such channels of communication are aligned with the village men's socio-cultural contexts and their communication practices? To unearth the channel(s) and means of communication that the local nurses used to

communicate messages about eating a healthy diet to the men, and to establish if those channels were commensurate with the men's socio-cultural contexts and ways through which they communicated and shared information, a semi-structured interview method was used. Thus, the focus of the semi-structured interviews was on the channels of communication that were used to disseminate information about eating a healthy diet to be able to determine the way forward for communicating health promotion messages in the villages.

The number of interviewees for this category was determined by the number of identified key informants in each village. All in all, six (6) local nurses from two villages were selected through a purposive sampling method using medical centres (clinics), gender, years of experience and years of working in the villages as selection criteria. Medical centres were used to ensure that all the two villages' clinics were represented in the population of the respondents. Thus, each village was represented by three nurses. Gender was used as a criterion to avoid a situation where the study population would comprise only one gender group. Accordingly, the study population comprised two male nurses and four female nurses. Equality in the number of male and female nurses could not be achieved due to an inherently small number of male nurses in the clinics. A conscious decision was also made to ensure that only experienced nurses who had been working in the selected villages for longer periods were eligible for inclusion in the study population. Thus, all the nurses who constituted the study population had more than five years of experience of practising as nurses and more than two years of working in the selected villages.

### 3.2. Unstructured Interview

To find out what made the men in the villages resist a change to healthy eating habits despite the spirited campaign for eating healthy foods by the nurses, and the apparent possession of knowledge on the benefits of eating a healthy diet, the following question was asked: Why do the men in the villages not give up unhealthy eating habits? To gather information from the village men and answer this question, an unstructured interview method was used. The researchers' brief in the use of unstructured interview included: finding out whether the village men had the knowledge about healthy diet, and how the information about healthy eating was dispatched to them and by whom. To get all these pieces of information, the researcher hung out with the men during funerals, public assemblies, and festivities to learn unobservable eating practices through interpersonal communication, and to ask them about healthy eating and how the information about healthy diet was communicated to them and by whom. To get women's

side of the narrative as key stakeholders in the men's health, the researchers also hung out with the women and asked them questions about cooking, food selection, and men's eating habits.

### 3.3. Data Analysis

Given the qualitative nature of this study, data was produced in the form of narratives of participants' responses. As a result, data analysis was largely interpretative, analytical and descriptive. The whole process of analysing data started with examining and interpreting the data by forming impressions and reporting those impressions using the coding guidelines proposed by the grounded theory [17]. The Grounded theory is an approach which is characterised by systematic processes of collecting, coding, analysing and sub-dividing data into categories using the information that emerges from the data itself [17]. Using the grounded theory approach, the coding enabled division and sub-division of data into themes and sub-themes embedded in the data.

## 4. Knowledge about Diet and the Communication Processes of the Local Nurses

### 4.1. We Are What We Eat: Men's Knowledge about Healthy Foods

When asked what kinds of foods are healthy, and which ones are not, the men's responses generally demonstrated a profound lack of knowledge about foods. Generally, they also did not show an understanding of the ramifications of eating unhealthy foods such as the development of non-communicable diseases and other associated risk factors [18]. The men's responses indicated that they did not care about knowing whether or not the food they ate was healthy. Here were some of their responses: "*I eat anything that my wife offers me. I never ask her if it is healthy or not*" and "*Do I have to know whether or not the food I eat is healthy? I don't care whether the food is healthy or not. All that I want is savoury food that I will enjoy eating and filling my stomach with*". These kinds of responses demonstrated a profound indifference about knowledge of food.

Some responses showed very little knowledge about which foods were healthy and which ones were not. Responses such as: "*Fruits are healthy and meat is not*" "*I am not sure but I think milk is healthy*" and "*Salt is not healthy. The nurse advised me to cut down on salt because I have High Blood Pressure*", indicated that some men had very little knowledge about foods.

**Table 1.** Men’s knowledge about Healthy Foods

Theme	Question	Objective	Responses	Conclusion
Knowledge about healthy foods	What kind of foods are healthy and which ones are not?	To find out how much knowledge about healthy diet the men had	<ul style="list-style-type: none"> <li>• I eat whatever food my wife offers me. I never ask if the food I am given is healthy or not</li> <li>• I don’t think it’s necessary for me to know if what I eat is healthy or not. All that I need is savoury food that I will enjoy eating and filling my stomach with.</li> <li>• Fruits are healthy and meat is not.</li> <li>• I am not sure, but I think milk is healthy.</li> <li>• Salt is not healthy. I was advised to cut on it</li> </ul>	The men did not have the knowledge about healthy and unhealthy foods

As these extracts show, except for meat, which was mentioned many times as unhealthy food, there was nothing that showed that the men had a good understanding of healthy and unhealthy foods. This might be an indication that messages about eating healthy foods had not reached or been understood by a lot of the men in the villages. Consequently, much needs to be done to craft strategies that would enable information about healthy eating to reach all the men. Table 1 presents a summary of data obtained from the remote village men and the conclusion drawn from their responses.

Through interactions with the villagers, more especially the women, it was established that common diet for remote villagers was traditional dishes which are comprised of maize, sorghum, beans, millet and vegetables (pumpkin leaves/bean leaves/wild spinach). Although these are organic, locally produced and classified as healthy foods and recommended for the prevention and management of cardiovascular diseases, the men only preferred them if meat was included as a relish. Also, the men preferred dishes such as magwinya commonly referred to as fat cakes (deep fried dough); *serobe* (mixture of animal intestines and tripe) and *seswaa* (pounded meat) that are “tasty” but unhealthy. The situation has not been helped by the encroachment of modern life in rural areas. Consequent to the encroachment of modern life in the villages, foods high in fats such as deep-fried chips, hot dogs, fat oils and many others were available in local shops. These provided readily available “tasty” but unhealthy foods in rural communities.

Despite the profound preference for savoury foods, the villagers had access to cheap and healthy foods such as wild vegetables and fruits. Also, healthy foods were readily available in the villages because many of the villagers were subsistence arable farmers who produced healthy foods such as beans, sorghum, millet, maize and many other kinds of food. This indicates that it was not due to unavailability of healthy foods that the men ate unhealthy foods. It was primarily due to their preference for savoury and tasty foods that they ate unhealthy foods.

**4.2. Aligning Information about Healthy Diet to Village Men’s Cultural Contexts**

Nurses were asked how they ensured that the men identified with messages about healthy diet. In asking the

respondents this question, the objective was to find out whether or not messages about healthy diet put the men in rural village’s cultural orientations and communication practices at the pinnacle of their planning and communication processes. Following Lorber and Moore’s argument [19] that in every society the communication of health and illness is a social construct, and that it is shaped by the cultural orientations and values of the society, the authors of this paper wanted to find out whether or not messages about healthy diet were sensitive to remote village men’s unique social circumstances and were incorporating into their communication processes the ways through which such men crafted their social realities.

The respondents indicated that to make messages effective and appealing to the men, they mostly used Setswana in oral communication when the men came to them for medical attention. In instances where they have public campaign health talks which target all the villagers including the men, the messages are made to reflect the cultural values of remote villagers through the use of cultural themes, common proverbs and local and indigenous media such as music and dance, poetry and theatre. Threats and severity were also incorporated into their talks to appeal to remote communities’ emotional and aesthetic values and encourage them to act and change their unhealthy eating behaviours. When asked how often they held health talks with the villagers, the nurses intimated that health talks on various health issues (not necessarily on healthy diet) were held often at the clinics in the mornings before the beginning of consultations. One on one talks with affected patients were held in consultation rooms when patients had come for medical assistance. Public campaigns were organized intermittently also on various health issues, not necessarily on eating healthy foods. Based on Lorber and Moore’s theoretical pronouncement [19], it can be safely said that nurses’ responses showed that their communication processes were consistent with the tenets of the culture-centred communication framework. Despite the apparent methodical delivery of health messages, the frequency in which health campaigns on healthy diet were held makes it doubtful that they benefitted the village men.

As argued elsewhere in this paper, health promotion practitioners who in this case are local nurses came from a

culture that was completely different from that of the rural village men. Consequently, they needed a thorough understanding of remote village communities' language, values, beliefs and other cultural practices, including symbolic non-verbal communication cues, such as gestures and images, and to be able to incorporate these in their communication processes. Taking cognizance of the men's cultural orientations during the development and delivery of health promotion messages might enable them to cope with the cultural diversity in the villages, gain respect and credibility with the villagers, reduce chances of misunderstandings, and generally make their talks effective and appealing to village men.

#### **4.3. Channels and Techniques of Communication for Messages about Healthy Eating**

Rodgers and Veil [6] suggest that effective delivery of health messages depends on health promoters' choice and use of channels that are most likely to reach target audiences. In view of this pronouncement, it was considered appropriate to assess the channels of communication that were used by local nurses in terms of their viability and potential to reach remote villagers, and to determine whether or not the diffusion of messages about healthy diet was done in ways that were beneficial to the village men. Thus, respondents were asked about communication channels that they used to disseminate messages about healthy diet. The objective of this question was to find out whether or not health promoters used channels and communication techniques that had connections with the socio-cultural contexts of the village men and the ways the village men constructed their social realities. This question was premised on Sponselee et al [18] and Jelicich and Braun [20] that the success of any communicative event is dependent on the choice of appropriate communication channels and techniques.

The respondents indicated that at the clinic, information was communicated through spoken means in the form of

face-to-face communication. During health talks, spoken means of communication were used such as: speeches, theatre (drama), song and dance, festivals, local dances, testimonies, health talks, and home visits. As one of the respondents indicated *"many villagers cannot read and write. So, the only option that we are left with is to use oral forms of communication"*. The respondents further indicated that during public health talks, they used theatre, festivals, local dances and songs to increase the villagers' participation and attract them to the talks, while testimonies helped the villagers gain firsthand information about the impact of unhealthy diet from the people who were already in poor health or their families. They contended that in most cases, testimonies were frightening and as such, were very effective in terms of increasing the response efficacy of remote villagers. Regarding the advantages of speeches, the respondents indicated that: *"they enable us to evaluate audiences' level of understanding during the delivery of the messages by observing their non-verbal cues"* and *"they enable us to get instant feedback from the audiences and be able to answer their questions and instantaneously clarify issues that arise from the delivery of our messages"*.

As discussed in section one, remote village communication environments emphasize and privilege oral and face-to-face communication. Considering this, the emphasis on spoken face-to-face forms of communication by health promoters signified an attempt to integrate healthy diet information into the communication environments and flows of interpersonal communication operating in remote villages. This was ideal for the village men who, as shown in Section One, communicated orally between themselves as individuals, groups and communities. Face-to-face oral forms of communication have the potential to empower and enhance people at the margins' control over their lives and health as they do not follow top-down channels [21]. The following table presents a summary of data obtained from the local nurses and the conclusion drawn from their responses.

**Table 2.** Local Nurses' Communication Processes and Channels of Communication

Theme	Question	Objective	Responses	Conclusion
Alignment of Health Information to cultural contexts	How do you ensure that the men the villages identify with your messages about healthy eating?	To find out whether messages about healthy diet were crafted around the men's cultural orientations and communication practices.	<ul style="list-style-type: none"> <li>• Mostly use Setswana (local language) to communicate messages about healthy diet through spoken mode</li> <li>• Messages reflect cultural values of target audience</li> <li>• Threats and severity incorporated into the talks to appeal to emotional and aesthetic values</li> <li>• Held talks very often</li> <li>• Held one on one talks with affected patients</li> </ul>	Nurses' Communication processes were consistent with the principles of the culture-centred-communication framework.
Appropriateness of Channels of Communication used to disseminate messages about healthy eating	What communication channels do you use to communicate information about healthy diet?	To find out whether the channels and communication techniques used had connections with the socio-cultural contexts of the village men.	<ul style="list-style-type: none"> <li>• At the clinics, information was communicated through spoken means (face to face communication).</li> <li>• During health talks, speeches, theatre, song and dance, festivals, local dances, testimonies, and home visits were used.</li> </ul>	The channels and techniques used were suitable to the men's communication environments which emphasize and privilege oral face-to-face communication.

## 5. Conclusions

The long-standing tradition of cooking and food selection being a feminized domain has made educating the men in remote rural communities on healthy diet very difficult. This explains why despite the methodically planned, and on the whole proper and well executed communication practices, the men in the villages still expressed little interest in, and concern about eating healthily. It should be concerning that the men demonstrated profound deficiency in the knowledge about healthy foods, including even those whose health had been affected by eating unhealthy foods. The results have shown that men's deficiency in the knowledge about healthy foods emanated from two factors: infrequent health campaigns and the fact that generally the men are never keen to visit health centres even when they are not well. Premised on this, local nurses should try to organize many health campaigns and should, if possible, follow the men even to the farms where they spend most days. Waiting for them to come to the clinics may not yield positive outcomes given their reluctance to visit clinics even when they are not well.

The findings on the language and channels of communication that were used to relay messages about healthy diet, indicate that an effort was made to embrace and incorporate the cultural expressions of remote villagers into the communication processes about eating healthily. It can, therefore, be concluded that in using community-based channels and the local language to disseminate messages about healthy diet, the nurses were demonstrating an appreciation of, and an understanding of the importance

of taking cognizance of the ways through which rural village men constructed their social realities. Engaging in cultural performances and using song and dance to disseminate messages about healthy foods would inevitably make remote villagers active participants in health talks and campaigns.

There is also a need for the adoption and utilization of the diffusion of innovation theory in the health campaigns on healthy eating that target the men in the villages. The utility of this theory lies in the fact that it endorses and emphasizes homophilous communication. This makes it the most apposite and most likely to be effective in communicating information about health to the villagers. Local nurses should therefore use this theory when diffusing messages about the benefits of eating healthy foods. The concept of homophily demonstrates that opinion leaders may have greater influence in the adoption processes of innovations in their communities and serve as pacesetters for the diffusion and adoption of health messages. This is so because opinion leaders are influential, enlightened, and innovative. They also have higher social status than many within social groups. As such, it is highly likely for interpersonal communication channels propagated by opinion leaders in the villages to have a profound influence on the diffusion and adoption of gouty arthritis awareness, prevention and management information. This means that; instead of the local nurses directly communicating messages about healthy eating to the men, they should induct and use informed and highly respected local people with similar characteristics as the villagers to spearhead the communication of messages on

healthy eating.

### 5.1. Limitation of the Research and Suggestion for Future Research

Despite accomplishing its overall aim of identifying what is useful in health communication targeting rural and remote villages in Botswana, this study has one overriding limitation; that is, the research was conducted in only two villages. Given that Botswana has many villages, two villages were not an ideal representation. Although remote rural communities in Botswana are generally organized around the same socio-economic and political circumstances, and they generally have similar lifestyle choices and cultural sense-making practices, it should be recognized that they have variations in cultural subtleties which influence how they understand and interpret health information. Probably these cultural variations could have been identified if more than two villages were studied. However, this being a small research study, studying many villages was not possible.

The media that have been suggested for disseminating health campaign information in remote villages such as theatrical performances and face-to-face live communication are suited to the villagers. However, there is still a need to consider channels of communication that could reach wider rural audiences simultaneously. Although Botswana does not have community radio stations, and the establishment of community radio stations would need government approval and support, future research should examine the roles community radio stations could play if they featured local events, materials and human resources that have commonalities with the remote villagers.

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