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Interdisciplinary Perspectives: Rethinking Communication for Development and Social Change in Health Communication

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Abstract: Communication for development and social change is an evolving field both in research and practice, transcending paradigms of conventional communication towards engaging and somewhat exposing some of the real-life communicative disorders experienced by communities. While public health and communication for development and social change operate from diverse paradigmatic thinking and are applied quite independently as disciplinary fields of study, health communication converges these fields in research and practice. In this paper, I discuss these interdisciplinary perspectives that draw from communication for development and social change principles and public health through a process of divergence and convergence towards new ways of thinking about decision making. Much of this discourse stems from understanding many health problems as a development problem first, one that recognises the role of community responses during pandemics yet at the same time places the agency back with individuals to make informed choices. Communicating for health decision making from this perspective is what I call Communicating for Health-as-Development (C4HD). C4HD foregrounds health as development, which caters to the messy, unidirectional, non-process-orientated, non-measurable and often non-data-driven approaches to health outcomes. It is in these messy health communication efforts that real development takes place. This paper, using examples from HIV and COVID-19, discusses these ongoing developments in the field and the convergence of public health and communication for development and social change from an interdisciplinary perspective, by exploring three key concepts: community engagement to influence decision making, community agency and ownership, and context and collaboration, which contribute to understanding communication for health-as-development.

Keywords: communication for development and social change; HIV and COVID-19 prevention; interdisciplinary health communication; public health; Communicating for Health-as-Development

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1. Introduction

Communication for development and social change (CDSC) is an ever-evolving field both in research and in practice, transcending paradigms of conventional communication towards engaging and somewhat exposing some of the real-life communicative disorders experienced by communities. It has re-engineered the field towards intentional communication of relevance. Still, CDSC has worked through the crevices of epistemic thinking and practice to challenge the modus operandi of health communication. This is particularly evident through social and behaviour change communication (SBCC), for which communication for development and social change is a key enabler to shift some of the dominant behavioural approaches when addressing human behaviour. The behavioural

conception of health contends that health decisions are rational thought processes and an outcome of individual rational actions (Betsch et al. 2016; Airhihenbuwa et al. 2014). Again, behavioural approaches to health communication take the position that culture expressed as traditional attitudes inhibits positive health outcomes among so-called primitive populations (Schiavo 2014; Waisbord and Obregon 2012; Dutta 2011). Some scholars have argued against the essentiality of behavioural approaches to health communication, which relegate the influence of the community and culture on health outcomes (Melkote and Steeves 2015; Waisbord and Obregon 2012; Dutta 2011). In contrast to behavioural approaches, CDSC-inspired health communication imperatives contend that context-specific cultural attributes, such as cultural norms and social expectations, contribute to understanding the influences of health outcomes (Waisbord and Obregon 2012), and whilst not always positive, it offers a more critical lens to understand behaviour and health imperatives.

Indeed, Airhihenbuwa et al. (2014) highlight that to achieve meaningful public health outcomes, culture, in addition to behavioural outcomes, must be interrogated. Health communication, particularly from the CDSC perspective, focuses on eliciting social change at the macro level by foregrounding local culture, to complement public health imperatives towards the improvement of community and individual health outcomes. Despite the seeming relevance of macro-level epistemic thinking, dominant-paradigm-inspired health communication fields have been dominated by an over-emphasis on individual behavioural change and micro-level issues. Again, in practice, public health and health-related CDSC have been applied quite independently as disciplinary fields, creating epistemic silos and less-than-desired programmatic stand-alone, albeit to improve individual and community health outcomes. Thus, what is needed is a shift in epistemic thinking from conceptual silos to an interdisciplinary perspective of health communication that recognises the complementarity of diverse social change-oriented fields, such as health communication and public health to improve health outcomes. To address this, this paper critically reflects on the interdisciplinary perspectives of health communication, focusing on social change at the macro level.

While public health and communication for development and social change operate from quite diverse paradigmatic thinking and disciplinary fields of study, health communication converges these fields in research and practice. Through the robust engagement of scholars in the field of communication for development and social change (Servaes 2020; Tufte and Tacchi 2020; Thomas 2014), health communication is now established more broadly on the agenda of development (Salmon and Poorisat 2020; Waisbord and Obregon 2012; Schiavo 2007; Piotrow et al. 2003), as well as public health. In many ways, communication for development and social change has chartered the way forward to an interdisciplinary perspective that collaboratively merges health communication and public health at the patient–provider, community, organisational and advocacy levels. The essence of such engagement is to create opportunities through this empowering process for individuals to make community-informed decisions, thereby inversely converging decision making to the individual level again to achieve positive health outcomes (see Zoller 2017; Zoller and Dutta 2019).

In this paper, I discuss these interdisciplinary perspectives that draw from communication for development and social change principles and public health through a process of divergence and convergence towards new ways of thinking about health and decision making. Specifically, I analyse the diverse directions of the development of the health communication field. Communicating for health decision making and positive behavioural outcomes through a social change perspective is what I call Communicating for Health-as-Development (C4HD). Much of this discourse stems from understanding many health problems as developmental and a public health issue. My early work in ‘development

and health communication for HIV/AIDS prevention' situates health first as a development problem and then as a public health problem (Govender 2011). This does not imply that pandemics should be devoid of rigorous public health intervention but that many behavioural change processes rest within wider development and social change issues (Govender 2021). Instead, C4HD thinking provides new insights into focusing on social change at the macro level for health communication during pandemics. This paper defines interdisciplinarity as acknowledging the complementarity of health communication and public health and drawing from their concepts, tactics and approaches to collaboratively communicate health-related social change during pandemics. This work defines a community as a group of people sharing similar social characteristics whose actions and inactions impact each other's health statuses and outcomes by virtue of their everyday interactions. Further, within C4HD, the role of the community as an actor in health communication is to provide the life context within which individual and community health can be understood. Again, the community is seen as having agency, empowered to engage in health interventions instead of recipients of such initiatives.

In this paper, I wish to explore how health communication from both a public health and communication for development and social change perspective has contributed to pandemic responses. Through this epistemic thinking, a new modality of communication has emerged, one that recognises community input as an integral part of the SBCC processes, while amplifying community voices in pandemic responses (Dutta et al. 2020; Essel and Govender 2023). Still, at the same time, agency is placed back with individuals to make positive health choices in times of public health emergencies. This suggests that we do not only approach a person during pandemics from a community level but ultimately recognise that decision making will occur on the individual level with community influence for pandemic communication. Drawing from research and practice in pandemics such as HIV and AIDS and later COVID-19, this paper explores the intersection of development communication and public health as an interdisciplinary perspective to C4HD that challenges the determinants of individual and community-level health outcomes during health emergencies.

2. Health Communication: Social Change Advances from Public Health

Health communication (HC), coined as a field in 1975 by the International Communication Association (ICA), was still primarily concentrated within this field of public health, dispersing health information with a sender–receiver approach often in the form of national campaigns, placing health issues on the agenda of news media and later promoting interpersonal patient–provider communication (Govender 2021). As a field, it combines theory and practice in understanding communication processes and changing human behaviour (Rimal and Lapinski 2009). Several leading books have been dedicated to defining health communication (Schiavo 2007; Bernhardt 2004; Harrington 2015; Cross et al. 2017; Schiavo 2014; Piotrow et al. 1997), many of which offer extensive insight from an interpersonal perspective, theorising and addressing effective communication with the patient–provider in healthcare settings. Some academics have explored health communication from a culture and media studies perspective (Dutta 2011; Airhihenbuwa 1995; Lupton 1994; Lewis 2014). However, few books address the intersection and even interdisciplinary nature of public health and health communication from a communication for development and social change perspective.

Health communication has become a well-recognised discipline linked to communication and health research (Ratzan 1994, p. 11) and public health in the era of epidemics, emerging diseases and increasing chronic diseases (Schiavo 2014). Public health adopts a post-positive perspective more specifically, focusing on primary health care, prevention,

protection, and promotion, with communication often being one approach in the arsenal of health promotion. Health, addressed primarily through public health strategies, without acknowledging the complementarity of CDSC-inspired health communication, can give less attention to the other developmental challenges (social, economic, physical and, religious) and nuances that influence health outcomes during pandemics.

Health communication, from this perspective, is a dominant paradigm associated with behaviourist paradigmatic thinking, and has an emphasis on the individual level of influence and decision making. (World Health Organization 2023) BCC uses communication as a tool to persuade individuals to adopt prescribed health behaviours (Green and Tones 2010). According to Pradip Thomas (2014), the commodification of BCC has reached epidemic proportions with individual projects devoid of context, often results-oriented through outcomes. Revisiting what the field of communication for social change brings through borrowing and adapting new theories, (Thomas 2014, p. 18) offers novel insights into established and new realities. For health communication, this means not denying the merit of understanding individual behaviour through the sciences but a transition from the sole medical model, which caps risk as the responsibility of the individual, towards engagement with social and structural factors that influence change (Green and Tones 2010).

These social change shifts are evident through social and behavioural change communication (SBCC) influenced by social determinants and multilevel enablers of change which are more concerned with collective action, often in the form of community engagement, social mobilisation and advocacy efforts (Thomas 2014). With COVID-19, risk communication and community engagement (RCCE) were mobilised as a new approach, shifting health communication into the active community engagement space (Gupta et al. 2021). Adopting multilevel theoretical approaches allows health communicators to provide meaningful input in improving and saving lives.

Hence, health communication from the public health and social change perspective is concerned with improving health outcomes (Gupta et al. 2021) but with a dualistic approach of engaging with communities, by mobilising individuals with informed, intentional health decision making. Communication for Health-as-Development (C4HD), from this perspective, works with public health and emphasises effective communication processes and community engagement to ultimately empower the individual decision-making process. This gives birth to a new paradigm of research, community engagement and practice, which does not only seek to conform or transform specific behaviours. Instead, communication is seen as a dialogical process of community engagement towards collective and individual health consensus. Yet, it is still a diverging and converging process that broadens into community narratives of influence on behaviour, and then narrows to individual decision making, placing the onus on the individual for positive health outcomes.

The field of health communication is, therefore, not confined, owned or solely transformed through public health. Rather, community-driven public health and health communication principles and tactics collectively contribute towards achieving positive health outcomes. Through empowering, enabling and agency-driven engagement processes of health communication, communities are empowered to advance their health choices. Just like community-driven public health imperatives, particularly for marginalised populations, Communication for Health-as-Development (C4HD) foregrounds development imperatives for social change that are messy, unidirectional, non-process-orientated, non-measurable and often not data-driven. It is in these messy health communication efforts that real development takes place.

3. Health Communication: Social Change Advances from Communication for Development

The work of Servaes and Lie (2013, 2020) positions health communication within development communication as a sub-discipline of the field of applied communication research. Recognised as a sub-discipline in communication, and as a discipline in public health, many scholars identify its multidisciplinary nature. Schiavo (2007, p. 7) defined health communication as a multi-faceted and multidisciplinary approach to reach audiences and share health-related information with the goal of influencing, engaging and supporting individuals, communities, health professionals, and policymakers to introduce, adopt and sustain a behaviour, practice or policy to improve health outcomes. Harrington (2015) similarly recognised the multi-disciplinary, interdisciplinary and transdisciplinary nature of health communication, but also highlighted the importance of collaborative investigation, with different disciplinary perspectives to explore a health or communication aspect of a health problem. Health communication is increasingly recognised for its diverse scholarship with interdisciplinary contributions (Nussbaum 1989; Walter 2016).

Tufte (2012) calls for a more explicit social vision and social ambition in health communication that favours a "broader-based interdisciplinary communication paradigm, where modernity, globalization and social change is well theorized" with "room and time for dialogue and debate guide our global health communication practice" (Tufte 2012, p. 613). As part of this process, Tufte flagged that the challenge for health communication remains in rethinking the role of media and communication in support of a development process and a public health vision where media (and communication) can better address the health concerns of populations (Tufte 2012, p. 617).

In revisiting this development process, interdisciplinary health communication scholarship, through the adoption of the ecological perspective, examines the relationship and connection between individuals, peers, families, communities and broader social, economic, cultural and physical environments. Research from this ecological perspective is conducted with various theoretical insights and principles that stem from humanities, social sciences and medical science, some of which reflect different paradigmatic approaches (Cohen 2022). As I think about interdisciplinarity, I ask, what does communication for development and social change mean for health communication?

The value of communication for development and social change and its contribution to health communication cannot be underestimated (Lie and Servaes 2015). Drawing from interpretative and critical–cultural perspectives, communication for health as development (C4HD) allows researchers to examine processes of engagement and its influence on decision making, community agency and ownership of health issues, placing increased emphasis on context and collaborative health goals. Through critical–cultural paradigms, these multiple ways of knowing and understanding health information, health promotion, patient–provider interactions and shared decision making (Hoffmann-Longtin et al. 2022) give a voice to marginalised communities to 'empower them for social change' (Harrington 2015, p. 20). Through "cultural constructions of health and responses to illness" (2017) and critically exploring and addressing the power relations, the co-production of knowledge with communities promotes progressive social change for health and development. So, as I think about the emerging developments in the field and what captures this convergence from public health and communication for development and social change in an interdisciplinary perspective, three key concepts inform what I call Communication for Health-as-Development. These include community engagement to influence decision making, community agency and ownership, and lastly, context and collaboration, which is an overarching perspective to successful effective health communication. These concepts are expanded below and explored using examples from two pandemics: HIV and COVID-19.

3.1. Community Engagement to Influence Decision Making

In Teer-Tomaselli et al. (2021), we discuss this approach where the adoption of health communication is through a lens of development communication, which explores new ways of harnessing media, particularly participatory media and methodologies, and local cultural frames to promote and advance health imperatives. Health communication from a communication for development and social change perspective challenges participation to ensure that "participation translates into individuals being active in development programmes and processes; they contribute ideas, take the initiative and articulate their needs and their problems, while asserting their autonomy" (Ascroft and Masilela 1994, p. 260). This participatory dimension of communication delves into the specifics of who these communities are, how they make sense of lived realities, and what interventions will contribute to positive health outcomes. Health communication from this perspective "is a long-term process that begins and ends with people's needs and preferences" where people are not merely targeted but active participants in the process of understanding and prioritising health issues, "finding culturally appropriate and cost-effective solutions, and becoming effectively engaged as the lead change designed in the planning, implementation and assessment of interventions" (Schiavo 2014, p. 12).

Communication for development and social change is concerned with processes and the way we communicate as the catalyst for the health outcome we expect; it is messy, as it challenges why people think the way they think about health and explores influences that contribute to a way of thinking and knowing. In many ways, communication for development and social change is more than applied health communication; it is about messy, unstructured critical ways of knowing, understanding and being as seen through the lens of communities. Yet the action or human behaviour that is necessary to achieve a health outcome is a result of this messy community engagement that ultimately influences individual decision making. It is at the level of the messiness of engaging in the development and social change that health communication and public health imperatives intersect.

The importance of collective voices in decision-making processes relates to health and social issues, where community-engaged health communication interventions echo a shared belief through community dialogues and voices, communities have greater ownership with shared health imperatives, they participate in health and social issues, and they collectively focus on local contexts in addressing the health issue (Schiavo et al. 2016). This is seen through the long HIV prevention trajectory of communicating health from a development and social change perspective to advance human behaviour and will be discussed below.

3.2. Community Agency and Ownership—Where the Power Lies

Given the conflicts in defining participation, which is often a buzzword coined in most development projects, Thomas (2014) argues that the dominant paradigm is yet to pass, as the participatory model has been co-opted within this perspective. Communication for development and social change as a field of research is positioned as the game changer in participatory communication; however, it runs the risk of over-emphasizing impact with a strong results-oriented agenda that can be institutionally and often funder-driven, leading to the corporatisation of health communication efforts. It must be noted here that, from a C4HD perspective, the actions and inactions of social actors within closely knit communities impact each other's health statuses and outcomes by virtue of their everyday interactions. As such, community agency, which Dutta (2011) conceptualised as the power of choice by communities, does not lie in the bosom of individuals but is a social construct. This paper borrows from Figueroa and his colleagues' conception of community ownership of communication for social change interventions. That is the extent to which communities feel responsible for the success of interventions and, therefore, credit themselves with it

(Figueroa et al. 2002). Following this, within C4HD, community agency leading to ownership of health imperatives should be centred in all health communication interventions.

Despite increased evidence on the centrality of community ownership and participation in health communication interventions, as was seen in many HIV efforts (Govender and Karim 2018; Govender 2011), the integration of community mobilization and citizen engagement strategies, which are key areas of health communication, is too often an afterthought in most communication programs (Schiavo et al. 2016). Also, little community input was evident in many COVID-19 responses targeting closely knit Global South communities with limited resources (Essel and Govender 2023; Pavarala and Jena 2020). Pradip Thomas questions if participation and empowerment have become dominant paradigms in CFSC, which has agenda-setting powers, placing global health funding on the agenda of health communication, as seen through the resources from the Bill and Melinda Foundation, which is supportive of an "individual focused neoliberal, big pharma approach to global health" (2019, p. 7).

For CFSC to be utilised in health communication, community experiences that are grounded in local ecologies of best practice (Thomas 2019, p. 46), where there is a critique of biomedical models of health (Waisbord and Obregon 2012, p. 20), offer opportunities to question the power of health communication. The strength of CFSC lies in addressing issues of power, human rights, and social justice. Thus, CFSC should not be overshadowed by the need to demonstrate results with predominantly quantitative evaluations and impact indicators (Pavarala 2020), negating the real impact in communities that sometimes cannot be measured. Power is not a new concept to CSFC, yet the 'power to decide, the power to impose, the power to resource, the power to create, the power to define and the power to invest' are all necessary to advance pandemic communication beyond data-driven outcomes of health interventions.

3.3. Contexts and Collaboration

The relevance of context is diminishing in global public health. It has been systematically ignored and marginalised in communication for social change theory, and this "neglect or marginalisation of context has been detrimental to community-based understandings of the needs that are grounded in culture and everyday life" (Thomas 2019, p. 3). Pradip Thomas's statement has been proven to be true in some instances, as witnessed by the top-down persuasive messages disseminated among communicatively marginalised Global South communities without community input during the COVID-19 pandemic (Dutta et al. 2020; Essel and Govender 2023). Understanding local contexts contributes to a nuanced understanding of development, social change, and advancing health communication.

The key to interdisciplinary health communication is also premised on the collaborative nature of scholars working from diverse disciplinary perspectives converging to explore a health problem. Often, this requires crossing bridges between communication and health professionals to utilise different approaches to gather data and evidence-based practice (Cohen 2022). However, from a communication for development perspective, health communication enables communities to be key collaborators in the co-production of knowledge and achieving health outcomes. Ultimately, the inclusion of individuals or communities will determine how we approach health outcomes, as social change is often influenced through multilevel processes of collaboration and engagement in interventions.

The Communicating for Health-as-Development (C4HD) perspective merges the merits of public health and theoretical contributions from communication for development and social change and suggests that this interdisciplinarity field draws on notions of community engagement and decision making, community ownership and agency, and

context and collaboration. I explore the merits of C4HD using examples from HIV and COVID-19 in South Africa.

4. HIV Prevention in South Africa: Are We There Yet?

In exploring these transitions of communication for development and social change responses, I first turn to the case of communicating HIV prevention in South Africa, which has had the highest rates of infections globally over a period of time (UNAIDS 2020). The early efforts of HIV communication in South Africa centred on the diffusion of health information, health propaganda, the adoption of Westernized ideologies and the health publicity paradigm that promoted the selling of acceptable health attitudes and practices (Johns Hopkins for Health and Education in South Africa (JHHESA) 2013; Govender 2011; Harrison et al. 2010). This dominant paradigm of social marketing, accompanied by health propaganda, disproportionately focused on individual attributes (Melkote and Steeves 2015; Waisbord and Obregon 2012; Dutta 2011; Airhihenbuwa and Obregon 2000), and was criticised for its inability to achieve behaviour change, thereby disrupting some genuine community attempts in South Africa to reduce HIV infection (Teer-Tomaselli et al. 2021). Many scholars argued that failure to consider cultural influence and the wider socio-cultural context limits the effectiveness of top-down approaches (Betsch et al. 2016; Schiavo 2014; Yehya and Dutta 2010; Dutta-Bergman 2005; Obregon and Mosquera 2005; Airhihenbuwa 1995), many of which were seen as efforts to modernise, normalise and conform society towards acceptable behaviour. Yet at the same time, relegating all rights and power to cultural acceptability and practice can perpetuate health problems and societal practices.

The early 1990s saw the dawn of a new democracy for South Africa but also the intensifying need to address the interconnectivity of behaviour, culture, religious ideologies and human health. The antiretroviral treatment program, prevention of mother-to-child transmission (PMTCT) program and ongoing medical male circumcision (MMC) dovetailed with behavioural change programmes to promote the adoption of new health practices in the South African epidemic (Simelela and Venter 2014). The early 2000s, however, saw heightened miscommunication around the treatment benefits of ARV, and SA was plagued by a decade of chronic misinformation, pseudo-science and conspiracy theories (Teer-Tomaselli et al. 2021; Sesanti 2018), with AIDS denialism often promoting the use of vitamins in fruit, vegetables and traditional cures instead of accessing ARV treatment (Cullinan and Thom 2009; Heywood 2004; Nattrass 2004). The frequent misinformation in the public domain and controversial medical conspiracy theories created doubt around the suitability and applicability of individual-oriented HIV/AIDS prevention efforts in South Africa, where health was not understood as a product of a complex interaction between the individual, the family and the community (Sidley 2007).

The Beyond Awareness Campaign (1996–2000), the first initiative undertaken by the National HIV/AIDS Directorate, undergirded the need to operationalise health communication (Parker et al. 2000) with cultural, social and economic factors foregrounded as key drivers for effective behavioural and social change response. An increase in participatory media (Parker et al. 2000) and culturally relevant participatory strategies using drama and forum theatre (Durden and Tomaselli 2012) challenged health education and the way we 'do' health, media and development. From 1998 to 2003, the ongoing community engagement, stakeholder engagement, advocacy and lobbying efforts of scientists, activists and civil society shifted the SA response with a scientific evidence-based strategy to support social mobilisation and advocate for access to antiretrovirals (O'Reilly 2016). Launched in 2009, Brothers for Life was an active social movement by men for men that encourage the uptake of health services, particularly testing and treatment. Using multi-media platforms and community events, the campaign mobilised men to actively engage in activities to

address Gender-Based Violence and HIV prevention in their communities (Mbasalaki 2014) and created a notable shift to a people-centred approach based on community mobilisation and collective action (Manyozo 2017; Dutta 2011; Figueroa et al. 2002).

The period between 2004 and 2014 saw an avalanche of communication interventions to curb misinformation; there was also a prominent rise and shift in the focus on behaviour change communication alone to combination prevention, which included biomedical intervention specifically with the use of antiretroviral for prevention as treatment (TasP), behavioural and structural interventions (Govender 2024). At the same time, shifts in the dominant paradigm of development were evident with the locally produced South African television Soul City, which adopted entertainment education (EE) with a social and behavioural change strategy (Tufte 2012), to significantly advance the South African public health agenda. Communicating for participatory development with an emphasis on community dialogue and collective action became a cornerstone for convergence where community-level interventions were necessary to understand local context and influence behaviour change (Kincaid and Figueroa 2009). Through the developments in HIV communication, communicating for health as development is mobilised by empowering ordinary people to actively find solutions to local problems, including health, which is critical for their involvement and programme sustainability (Fernández-Aballí Altamirano 2020; Tufte and Mefalopulos 2009).

The period of 2014 saw a major decline in communication efforts with the termination of many funded strategic social and behavioural change communication interventions (Gumede et al. 2022) and the increasing focus on PrEP, the first oral pill to reduce HIV infection by 90% (Govender and Karim 2018). However, the history of HIV communication from a communication for development and social change perspective in South Africa demonstrates the potential of various stakeholders addressing the importance of context and collaboratively working with communities to engage in dialogue and critically engage in the behavioural change process. With combination prevention, there is a heightened need for effective socio-behavioural change with medical literacy and understanding of medical technologies such as HIV treatments, HIV testing, viral load testing, male circumcision, microbicides, and pre- and post-exposure prophylaxis, all of which require communication with community engagement to address local contexts that are often cultural, economic and political (Kippax et al. 2011).

Advances made in revolutionising HIV communication over the last three decades to include community voices through community inclusion, social mobilisation and advocacy have been challenged by the shift from behavioural interventions to social change communication, but new emerging biomedical interventions which are less user-reliant, such as oral PreP, shift the agency and decision-making power back to the individual. This, in many ways, reaffirms the need for a process of divergence and convergence through communication efforts that engage with community needs and values, and then re-assesses its influence on individual decision making and the uptake of new innovations. In some ways, the culture-centred approach, context of communities and participatory ways of engaging communities to delve into their HIV prevention preferences sheds some light on and new insights into the uptake of these biomedical developments (Bokolo and Govender 2022; Govender and Karim 2018; Govender 2011). Placing the agency back with individuals for behaviour change and health choices for HIV prevention requires a broader socio-cultural context and often development challenges to be elevated to inform social change (Govender 2024). Any intervention in the epidemic, whether it is understood as "biomedical", "behavioural" or both, requires community engagement and mobilisation to make a difference (Adam 2011) and this has been evident in the case of HIV prevention in South Africa.

5. COVID-19 in South Africa: Have We Learnt Anything Yet?

COVID-19, like HIV communication, constituted much more than a biomedical problem but a major narrative and communication problem (Lewis et al. 2021). While South Africa was commended for its proactive and swift action to contain COVID-19 (United Nations South Africa 2020), its communicative response adopted a public health perspective with top-down communication and limited community engagement and participation around the dominant prevention messages in the early stages of the pandemic (Govender 2021). In many ways, the victories and successes of many of the later community engagement efforts for HIV prevention were absent from the COVID-19 communication space (Gumede et al. 2022; Jansen and Madhi 2022), which could also be expected given the public health emergency of COVID-19. However, as we reflect on the overall communication response with COVID-19, there are many lessons that can be explored for future pandemic and public health emergencies.

Top-down communication was evident through the globalised response of mask wearing, social distancing, personal hygiene and isolation/quarantine. The 'stay at home' message was a predominant message for many South Africans and attributed as a success of the initial COVID-19 response. However, this 'stay at home' message had severe consequences for many communities. For instance, resource-limited communities and disadvantaged communities were often forced to neglect COVID-19 lockdown restrictions, which sent large waves of poverty throughout the country, and increased unemployment rates with a further loss of 3 million jobs, and a surge of informal traders looking for alternate work. The contradictions to the 'stay at home' message emerged when people started to queue either for food supplies, donations, social grants or the debt relief programme that the government made available. Dominant public emergency responses needed more understanding of the wider social context and beneficiary community needs during pandemics (Govender 2021).

The key narrative emerging during this time was that COVID-19 prevention was possible if people 'stayed home', yet a dual pandemic, that of poverty, was escalating. A decade earlier, Campbell and Scott (2012, p. 177) asserted that "both globally and within particular countries and contexts, it is generally those with the most limited access to economic and political power who are the unhealthiest". Inequality played out in the form of unequal social relations and the underlying cause of health among disadvantaged groups, exacerbated further during pandemics such as COVID-19 and HIV/AIDS. The context within which people live is a crucial aspect of their health status (Dutta et al. 2020; Airhihenbuwa and Obregon 2000). The SA communication efforts aligned with global responses, where key messages focused on a very individual level of behaviour change, and limited efforts to integrate community responses. Concerns of modernization, cultural imperialism and Westernised approaches during pandemics were still evident (see Teer-Tomaselli et al. 2021), and COVID-19 communication, in many ways, followed a diffusion of health information, health propaganda, and the adoption of Westernised ideologies that were largely promoted by governments and key experts in the field (See Lewis et al. 2021; Lewis et al. 2024).

In previous pandemics like HIV, cultural practices were critically engaged, and agencies of communities were used as tools to address prevention. The COVID pandemic used key communication influencers who were predominantly political, health experts and powerful people in the community to reinforce global public health messages to different publics as the crisis evolved. The work of Dutta et al. (2020) here challenges this hegemonic pandemic communication for its ideology of individualism and its erasure of structural contexts and drivers of health inequalities. They further advance the need for community-driven health communication that is culturally centred. Dutta et al. (2020) foreground

questions of social justice during pandemic disease outbreaks, creating communicative infrastructures that facilitate advocacy and activism (see Lewis et al. 2021). Whilst community engagement is not always attainable during pandemics such as COVID-19, which was a public health emergency and a state of national disaster in many countries, the long-term management of COVID-19, with South Africa having one of the longest lockdowns globally, questions the overall impact of the intervention.

Further contradictions emerged with conflict in care. Many messages advocated for isolation and quarantine, yet this was extremely difficult in communities where communal living and a desire to protect each other exceeds self-care (Gumede and Govender 2024). In terms of isolation, families often isolated, with the care and support of families, and this resulted in many government facilities being under-utilised. In some ways, this could be a form of cultural resilience, rendering many of the health facilities and interventions irrelevant. The concept of Ubuntu—humanity for others—is deeply entrenched in community practice, and this became contested. Several studies during COVID suggested that Africa has made great strides through Ebola, TB, and HIV, and the value of social and community capital during pandemics cannot be overemphasised. Further, Ubuntu-inspired community responses to the COVID-19 pandemic challenge some of the dominant public health responses targeting individual behavioural change that emerged with COVID-19. Terry Flew aptly outlines that a deficit of trust lies at the heart of many communicative problems that emerged during the pandemic, occurring at professional, institutional and individual levels (Flew 2021) and the community level.

There is a need for 'rethinking pandemic responses in ways that were localised and people-centred, ensuring the inclusivity of local voices and experiences' (Govender 2021, p. 8). Expanding on this need for community engagement, several studies conducted in SA demonstrated the diversity and understanding of risk through community dialogues that addressed the local interpretations of COVID-19 prevention messages, suggesting high levels of knowledge and awareness of COVID-19 prevention measures (Rossouw et al. 2024). This position highlights a need for structural transformation of the environment where people live and work but not more paternalistic dissemination of WHO-inspired COVID-19 prevention messages (World Health Organization 2023). Thus, inherently health-promoting environments are expected to have healthier inhabitants compared to health-inhibiting settings. Efforts directed at promoting people's health will be much more impactful if they can remove barriers to health promotion in the environment within which people live and work (Schiavo 2014).

6. Towards Theorising a New Paradigm of Communicating for Health-As-Development

The transitions in HIV and COVID-19 prevention mirror the revolutionary nature of development communication in theory and practice, a field that is constantly re-crafted, re-constituted and re-engineered to ensure that voices of the community are not lost in the noise of global economic and political agendas. Health communication, with its progressive development and dynamic normative nature, re-amplifies the need for the inclusion of community voices in addressing health imperatives. My own research has contributed to re-visiting this interdisciplinary research through exploring the intersection of communication for development and social change with public health, and health communication.

In recent years, development programmes have seen a shift from focusing on a single health or development issue to encompassing multiple topics or issues within a programme. This shift is also reflected in the Sustainable Development Goals (SDGs) with the overlaps and interdisciplinarity of the global development areas. In global health, for example, the shift to an integrated approach draws attention to issues of universal health coverage,

primary health care, health system strengthening and client-centred care. Corresponding to this larger trend toward integrated development, there is an increased interest in integrated social and behaviour change communication that addresses multiple health issues and behaviours; this can be seen as a critical strategy to improve health and development outcomes (Johns Hopkins for Health and Education in South Africa (JHHESA) 2013). An integrated SBCC approach can often imply an interdisciplinary perspective, one that caters to the intersectionality of health, development and praxis within the frameworks of applied human sciences and biomedical research. Through the messiness of development in research and practice using the HIV and COVID examples, the role of community engagement in decision making and community ownership is increasingly recognised in health communication. Further, the importance of context and collaboration contributes to the development and social change in health communication.

Optimising these intersections in the health communication field contributes to future pandemics, expands our field's interdisciplinary strengths, and advances a health agenda. This is achieved through recognising the importance of community voices and ownership of decision making where community mobilisation as a form of development is integral in improving people's health. Campbell and Scott (2012) pointed out that community mobilisation is an integral approach to achieving the ideal of a 'health-enabling social environment'. Thus, community mobilisation (community participation, partnership and ownership) provides the fulcrum of the health-oriented social change process. Community mobilisation is defined in terms of (1) the intertwined strategies of grassroots participation in health and social development efforts (participation) and (2) the building of alliances and collaborations between communities and more powerful groups (partnerships)" (Campbell and Scott 2012, p. 178). Taking this lens, Communicating for Health-as-Development amplifies community engagement for informed health decision making at the individual level, community empowerment through ownership and enhancing collaboration. This collaborative nature through community participation and partnerships creates diverse opportunities for empowering beneficiary communities and individuals to achieve pressing health outcomes during pandemics. Against the background of the rapidly changing health messaging in response to the fluid nature of pandemics, it needs to be pointed out that changing health behaviour is a difficult task at any level, even among highly motivated individuals. This situation is more dire among people sceptical of prevention messages, as witnessed during the COVID-19 pandemic.

For successful pandemic responses, understanding the lived experiences and how global public health response messages are localized is imperative. To illustrate, Ebola in Western Africa highlights how a "*people's science*" (Richards 2016), through a mediated approach, explored local cultural practices. Again, integrating global messages into a local context was able to delve into the depths of some of the complexities around human behaviour towards eradicating some of the health challenges. Ebola, like HIV, worked with the power of community partnerships for an in-depth knowledge of prevention and treatment messages through cultural frames (Kunda and Tomaselli 2009; Govender and Karim 2018; Govender et al. 2017). The decisive role of communities provides an evidence-based reality to address health and development. The rise of community voices enables a "space for such acts of exchange, listening and narrative formation" (Mansell and Manyozo 2018, p. 327). It allows us to reflect, engage, critique and appreciate the contribution of local communities as key stakeholders and as research partners in the co-construction of knowledge in health and development.

This applied research and local stakeholder engagement illustrates the merit of research–community partnerships, albeit donor agencies drive their socio-economic agendas. This position is consistent with Bessette's (2004) assertion that a key factor in achieving

success with communication for development and social change initiatives is developing and nurturing local partnerships between and among identified stakeholders. Partnerships can be between communication researchers and locally identified stakeholders and/or between locals and powerful external groups (Bessette 2004). From a health communication inspired by communication for development and social change perspective, such a researcher–community partnership is even more crucial. This position is buttressed by the treatise that the primary role of health communicators is to provide alternative social spaces conducive to marginalised populations seeking social recognition and enacting their resistance against forms of social hierarchies responsible for health inequalities (Campbell and Scott 2012).

Health communication inspired by communication for development and social change models and approaches relies on an increasing sense of community ownership, information equity, social norms and collective self-efficacy (Pavarala 2020; Thomas 2014; Figueroa et al. 2002). Inherently, these developments in research and practice support the urgency for community collaboration with an understanding of the context that influences health behaviours. Such an approach creates spaces for community mobilisation that, in many ways, also reflects the interdisciplinary nature of public health and communication for development and social change.

7. Conclusions

Pandemics like HIV have seen the dispersing of health information largely driven by communication experts, an increased emphasis on patient–provider interventions under the ambit of health promotion, and some communication for participatory development interventions driven by a development agenda with communities. Scholarship in the field of health communication is therefore diverse with interdisciplinary contributions that specifically contribute to health information, health promotion, patient–provider interactions, and shared/collective decision-making processes, and this interdisciplinarity encourages multiple ways of knowing (Hoffmann-Longtin et al. 2022). Whilst an ongoing pandemic like HIV has allowed for layers of community engagement at various stages of prevention efforts, public health emergencies like COVID-19 necessitated a firm and much-needed epidemiological response; the problem arises, though, when pandemic communication adopts Western messages without understanding localised experiences in the adaptability of key messaging (Laskar and Bhattacharyya 2021; Dutta et al. 2020; Pavarala and Jena 2020). The case of HIV prevention has, in many ways, demonstrated the value of communication for health-as-development, and at the same time highlights how the shifts in prevention approaches cause a revisiting of the value of moving from individual levels to community levels of engagement and then converging back to the individual level again for community-influenced individual decision making. Whilst this paper has focused on the interdisciplinarity of health communication, this paper is somewhat limited in its examples from South Africa only, and drawing from only two pandemics as examples; however, given the extent of infections, death and disease management within the country, and the extensive communication for social change initiatives, this paper offers an evidence-based perspective from the Global South.

This paper discussed Communicating for Health-as-Development (C4HD) as an interdisciplinary approach to communicating health. The Communicating for Health-as-Development perspective merges the merits of public health and theoretical contributions from communication for development and social change and suggests that this interdisciplinarity field draws on notions of community engagement and decision making, community ownership and agency, and context and collaboration to communicate health. The interdisciplinary approach to health communication emphasises a shift from individual

behaviour change to macro-level change, often at the community level, where wider collaborative and socio-ecological perspectives are needed for health-as-development, which is deeply entrenched in the communication for development and social change perspective.

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