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ABSTRACT
Botswana is in the grip of an epidemic posed by diabetes, and remote rural area settlements have also been identified as being at risk due to: lifestyle changes, less physical exercises, excessive alcohol drinking, smoking and eating unhealthy diet. In the light of this problem, and the fact that the lack of knowledge about the causes of diabetes and how to prevent it is emblematic of remote rural area settlements, the homophilous communication method is used to reach remote area people with the information about diabetes. Given the fact that the concept of ‘homophilous communication’ has been conceived and developed in Western communication environments where the idea of the problem of diabetes and the development of scientific knowledge about diabetes first emerged, the objective of this study was twofold: First, it sought to find out how homophilous communication is integrated into the communication environments of remote villages. Second, it aimed to investigate whether or not the homophilous communication method is used in ways that are bound-up with remote villagers’ communication practices, cultural orientations, and ways through which they craft their social realities. Driven by the Diffusion of Innovation Theory, and the hypothesis of connection, this study used two methods: participant observer method and interviewing of diabetes health promoters. The results show that homophilous communication is being effectively adapted to remote villagers’communication environments which emphasize and privilege interpersonal forms of communication.

BACKGROUND INFORMATION
Due to processes of rural-urban migration and lifestyle changes, there is a significant increase in the prevalence of diabetes in remote rural areas of Botswana (Gill et.al, p. 2009, p. 9). The increase in the prevalence of diabetes in remote settlements has in turn inevitably led to an increase in morbidity and mortality rates in Botswana (Moeti 2013). Even though Botswana remote rural area communities are still dependent on agriculture for their livelihood, and there are no industries in remote rural areas, there are close ties between urban dwellers and remote villagers. These close relationships have led to the encroachment of modern life into remote rural areas (Norr, Tlou and Matsshediso 2004, p. 212). Also, on account of the close ties between urban dweller and the influence of modern life, there is an increased consumption of foods high in fats and refined carbohydrates in remote rural areas, a factor that contributes to increased prevalence of diabetes (Sabone 2008, p. 365; Koosaletse 2002, p. 1). Through observation and interaction with remote villagers during fieldwork, it emerged that many families have members who work in the cities and urban centres, and that those family members periodically bring foods high in fats and refined carbohydrates to remote villages. Also, there are general dealers and kiosks in the villages which sell such foods. As a result, there is a greater choice of food available in shops that did not exist many years ago in remote rural settlements (Koosaletse 2002, p. 1), hence the increase in prevalence of diabetes.

It is estimated that Botswana experiences 4.1 per cent diabetes prevalence rates (Mokgweetsinyana 2011, p. 1). This figure shows that diabetes in Botswana is ominous, and it is higher than the overall estimated diabetes prevalence in sub-Saharan Africa which stands at 3.1 per cent (Gill et.al 2009, p. 10; Mokgweetsinyana 2011, p. 1). Indeed official figures about diabetes prevalence rates in sub-Saharan Africa show that Botswana is the most affected country in sub-Saharan Africa (Gill et.al 2009, p. 10).

In the light of this problem, and the possibility of further and significant prevalence if there are no interventions, the Diabetes Association of Botswana, an independent and autonomous NGO, and the Ministry of Health run diabetes health campaigns to educate remote villagers about this pandemic. The officials of these two organizations, hereafter referred to as diabetes health promotion practitioners, are different from remote villagers in terms of culture and ways of communication. They also use methods of communication that have been conceived and developed in Western Communication environments. It is against this backdrop that this study has been developed with the main objective of finding out whether or not the diffusion of diabetes campaign messages is effectively integrated into the communication environments of remote villages which emphasize and privilege different interpersonal forms of communication.

The Diffusion of Health Promotion Messages: A Homophilous Communication Standpoint
The field of health communication is rooted in a number of models and theories. Those theories and models have been developed in order to achieve effectiveness in the delivery of health promotion messages and to enable health promoters reach all sectors of target audiences with health messages (Rodgers and Veil 2008; Dutta 2008). Among those theories is the Diffusion of Innovation Model (Ntubam and Harris 2004; Schiavo 2007). The Diffusion of Innovation Theory propagates for the use of interpersonal channels on the grounds that they are more effective in persuading individuals to accept new ideas and can reach all people in the social system (Rodgers and Veil 2008, p. 7). In the Diffusion of Innovation framework, an innovation is defined as an idea that is new to an adopter, while diffusion entails communicating an idea through certain channels overtime among members of the social group (Rodgers and Veil 2008, p. 7). If an idea is perceived by the community as new, then it is considered an innovation (Goodman-Brown 2012, p. 175). Put differently, the diffusion of innovation means ways through which new ideas are communicated to target audiences (Goodman-Brown 2012, p. 175).
The adoption of a new idea follows a five stage decision making process which covers: knowledge, persuasion, decision, implementation and confirmation respectively (Rodgers and Veil 2008, p. 7). The knowledge 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 (Rodgers and Veil 2008, p. 7). 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 if they adopted it in the decision stage. The confirmation stage involves seeking a reinforcement of the decision to adopt a new idea in order to reduce any misgivings adopters may have about that new idea (Rodgers and Veil’s 2008, p. 7).

The implication of the adoption of innovation process to diabetes health campaigns is that; diabetes health promoters have to fully understand remote communities prior to communicating diabetes campaign information to them. The Diffusion of Innovation Theory provides an insight into the communication processes that could enable remote villagers adopt new ideas about diabetes. For instance, the diffusion of innovation framework shows that the diffusion of diabetes awareness, prevention and management information can occur through a decision-making process whereby remote villagers evaluate the adoption of diet and lifestyle changes that can reduce diabetes risk factors and improve their capacity to manage and cope with diabetes condition.

Goodman-Brown (2012, p. 178) contends that communities are most likely to embrace new ideas if they find them bringing clearer advantages, and are linked with their values and norms. But then, for people to find value in any piece of information and be able to make decisions based on it, they have to enjoy access to channels that carry the said information (Popovic et.al 2013, p. 23). Rodgers and Veil (2008, p. 7) and Goodman-Brown (2012, p. 175) argue that interpersonal channels, although not as quick as mass media in terms of transferring messages, are the most effective in terms of persuasion, especially when they link two or more individuals who are similar. Just like Rodger and Veil (2008), Dunlop et.al (2008) also emphasize the effectiveness of interpersonal channels of communication over mass media. Dunlop et.al (2008, p. 2) posit that 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.

The pronouncements on the utility of interpersonal channels of communication indicate that it might benefit diabetes health campaigns in remote rural areas if diabetes health messages were diffused through community sponsored interpersonal channels of communication. This insight is derived from the fact that interpersonal communication channels are emphasized and privileged by remote village communication environments. Furthermore, community sponsored interpersonal channels of communication would significantly benefit diabetes health campaigns because they take recognize of the importance of the voice and language, and cultural viewpoints of the community and would most likely facilitate the contextualization of diabetes health issues to make them more relevant to remote villagers. In the light of this, and alsoas confirmed by Rodgers and Veil (2008, p. 8), it appeared that the effectiveness of the diffusion of diabetes campaign messages in remote villages would depend entirely on the utilization of interactive channels of communication that enhance homophilous communication. It is in the light of this that this study sought to find out how homophilous communication was used to reach the villagers with diabetes health messages, and whether or not the communication processes of diabetes health promoters took cognizance of the cultural orientations of remote villagers.

Homophily is the degree to which interacting individuals have similar social attributes such as beliefs, education, language, and social status (Rodgers and Veil 2008, p. 8). When homophilous communication is used to propagate the dissemination of health messages, new ideas are likely to have greater effects in terms of knowledge gain, positive attitude formation and overt behaviour change (Goodman-Brown 2012, p. 178; Rodgers and Veil 2008, p. 8). Given that homophilous communication is driven by interpersonal communication channels, it enables the sharing of meanings and mutual belief or cultural languages based on closeness. This chiefly makes it the most appropriate and the most likely to be more effective in communicating information to people at the margins as such remote villagers.

The concept of homophily demonstrates that opinion leaders might have greater influence in the adoption processes of new ideas about diabetes in remote villagers. Given that, interpersonal communication channels are the means of communication for opinion leaders in remote villages, they (opinion leaders) are likely to have a profound influence in the diffusion and adoption of diabetes awareness, prevention and management information in remote communities. As Rodgers and Veil (2008, p. 8) would confirm, the fact that opinion leaders are the most influential, enlightened, innovative, and have higher social statuses than many within their social systems put them in a better position to serve as pace setters for the diffusion and adoption of diabetes health messages.

The endorsement of opinion leaders to propagate the diffusion and adoption processes of diabetes health messages is informed by Rodgers and Veil’s ( 2008, p. 11) assertion that health information is most trusted and best adopted by a community when it comes from a source within the same community. Also, common communication challenges that are normally faced by health promoters working with minority communities attest to the necessity of involving some influential villagers in the dissemination of diabetes health messages. Rodgers and Veil (2008, p. 10) enumerate a number of challenges that are faced by health promoters disseminating information in the majority world. First, there are differences in cultural experiences, perceptions of risk and crisis and appropriate response to such crisis. Second, language always poses a challenge. In most cases it is not the content or the subject matter that matters most in stimulating viewers’ interest in the information presented to them. Rather, it is the communicator’s ability to prove membership of the community through the use of local languages. Lastly, there is a problem of differences in translation and cultural viewpoints. Rodgers and Veil’s (2008, p. 1) example of misinterpretation of cancer by Native American community when it comes from a source within the same community. Also, common communication challenges that are normally faced by health promoters working with minority communities attest to the necessity of involving some influential villagers in the dissemination of diabetes health messages. Rodgers and Veil (2008, p. 10) enumerate a number of challenges that are faced by health promoters disseminating information in the majority world. First, there are differences in cultural experiences, perceptions of risk and crisis and appropriate response to such crisis. Second, language always poses a challenge. In most cases it is not the content or the subject matter that matters most in stimulating viewers’ interest in the information presented to them. Rather, it is the communicator’s ability to prove membership of the community through the use of local languages. Lastly, there is a problem of differences in translation and cultural viewpoints. Rodgers and Veil’s (2008, p. 1) example of misinterpretation of cancer by Native American community when it comes from a source within the same community.
In addition to using opinion leaders to facilitate the flow of interpersonal communication about diabetes health campaign information in remote rural areas, narrative techniques that are bound-up with the cultural expressions of remote villagers can also be considered. Dunlop et.al (2008, p. 2) contend that although the impact of narrative messages is dependent upon the extent to which the consumer becomes involved, it is increasingly being considered to be very effective as a persuasive message format for public health promotion messages. Dunlop et.al (2008, p. 2) opine that when listening or reading a narrative message, people become lost or absorbed into the story, a phenomenon they call 'transportation'. They argue that through transportation, an increase in emotional responding and making the story personally relevant is occasioned, thus resulting in a change in people's beliefs and attitudes about a health issue.

Emotional responses (fearfulness, anxiety, disgust, guilt and sadness) to narrative messages such as testimonies may stimulate fear on behaviour and constrain bad intentions (Dunlop et.al 2008, p. 2). To ensure that narrative messages have a profound impact on the target audiences, they (messages) should be related to the same target groups so that they (target group) can think about their health behaviours and what would be like if the events encapsulated in the narratives could happen to them (Dunlop et.al 2008, p. 2). The impact of narratives as effective health promotion techniques can be summarized through a simple chain reaction: transportation elicits self-referencing, which in turn generates emotional responses which influence behaviour change (Dunlop et.al 2008, p. 2). This chain reaction demonstrates that health risk perceptions are instrumental in behaviour change. It also demonstrates that narrative persuasive messages should involve an increase in risk perceptions. Given that oral, face-to-face narrations and conversations are the hallmarks of remote villagers' cultural expressions, they were deemed potentially capable of enhancing homophilous communication of diabetes campaign messages and stimulating positive behaviour change in remote villages of Botswana.

METHOD
This study involved the use of two methods: participant observation and semi structured interviewing. The interview questions revolved around the strategies that diabetes health promoters used to effectively reach remote villagers with diabetes campaigns messages. Participant observation method involved observing diabetes public wellness talks in remote villages. Participant observations started in the build up to the public campaigns. As mentioned above, the effective delivery of messages to target audiences can be achieved through having communicators who have the same or similar socio-cultural attributes as the target audience and paying attention to the audience's cultural and communication practices, including the social context. Participant observation, therefore, entailed looking into who conveyed diabetes health messages to remote rural area dwellers, how they conveyed the messages, and how the messages adhered to the cultural orientations of remote villagers in terms of content, language and the media used.

Integrating Homophilous Communication into the Communication Environments of Remote Villages.
The findings have shown that the involvement of remote communities in diabetes health campaigns is done through a WHO STEPwise approach. Interview respondents indicated that this approach is called STEPwise because it involves following certain steps or stages in the promotion of health. The respondents further indicated that prior to the commencement of diabetes health campaigns, diabetes health promoters in conjunction with communities, weigh the magnitude of the disease through observations, focus groups, and interviews and decide on what is to be communicated and how that could be communicated. The respondents further indicated that during the implementation stage, communities are involved through the engagement of Family Welfare Educators, some key informants, and ordinary community members who are invited to give testimonies during public campaigns. The evaluation of diabetes health campaigns also involve communities through the use of a selected and enlightened members of communities. Through participant observation, it was established that diabetes health promotion practitioners emphasized interactive face-to-face channels of communication. The actual public wellness talks started with the participants dancing and singing local music and citing traditional poems. The participants also walked around the village wearing T-shirts with diabetes health messages and carrying placards. There are three important observations that need to be made about starting diabetes health campaigns with poetry, music and dance. First, oral poetry and local music and dance are part of rural communities' culture. Every important event in the communities is normally started with music, dance and oral poetry, with the lyrics and poems depicting the event that is being celebrated. In the case of diabetes wellness talks, the lyrics and poems portray diabetes health messages. It can therefore be concluded that in starting the campaigns with oral poetry and music and dance, campaign organizers wanted to align the campaigns to the culture of remote villagers. Second, the use of traditional poetry and local music and dance significantly encouraged active participation by participants. Local music and dance, and traditional poetry are typical local resources when it comes to communicating information to remote rural area communities. They also enhance local participation. One of the corner-stones of the culture-centred approach is the use of local material and human resources, and active participation by the recipients of health information (Caplan 2003, p. 59). It can therefore be concluded that based on the use of traditional poetry, music and dance, diabetes health campaigns emphasized and explicated the notion of culture sensitivity.

Following the singing, dancing and recital of poems by the participants, diabetes health promoters gave speeches on diabetes, with emphasis on prevention and management of the disease. The message content was mostly conveyed orally in the local language. Some community members were used to give testimonials and share their experiences about diabetes during the campaign. Presenting diabetes health information orally and in the local language was consistent with the culture centred approach to communicating health information and they ways remote villagers generate knowledge and share information. The use of local language took cognizance of remote communities' unique social characteristics and lifestyles which are primarily organized around their unique social locations. Because remote villagers comprise mostly the poor and illiterate people, the dissemination of diabetes health messages in the local language was hugely connected with their identities as poor, illiterate people many of whom only speak the local language.

During the talks, some villagers who were diabetic were invited to share their experiences about the disease with the audience. For instance, in the first public wellness talk, the first to talk was a man who indicated that he was diagnosed with type 2 diabetes a long time ago. He indicated that due to failure to follow local nurses' advice on how to manage the disease, he is now impotent. Given the supposedly importance of sex in sexual relationships and sustenance of marriages,
the disclosure by a diabetic that he was experiencing serious erectile problems due to diabetes vividly caused fear on men who attended the campaigns. A blind woman who had lost all her teeth due to diabetes was also invited to address the audience. The third and last to talk was a wheelchair bound woman who indicated that she lost her limbs due to diabetes. It was not difficult to glean the impact of the three stories on the audience. Many of them were terribly shaken and overpowered by emotions. After the talk, the few men who had attended the talks openly talked about how losing their sexual prowess would be a blow to them and their wives. It then surfaced that having people who have been affected by the disease share their adverse experiences about the disease instilled fear on the audience.

CONCLUSION
The emphasis on spoken face-to-face forms of communication by diabetes health promoters during the wellness talks signified an attempt to integrate diabetes health information into the communication environments and flows of interpersonal communication operating in remote villages. The participants’ responses to the question on the involvement of rural area communities also showed that there is an attempt by diabetes health promoters to foreground the active involvement of target audiences in all the stages of campaign programmes. In line with Dutta’s (2008, p. 56) observation that health promotion messages must recognize that different social groups are capable of defining their own health needs and determine solutions to those health needs, there existed dialogue and mutual understanding between diabetes health promotion practitioners and the villagers. It is, therefore, possible that the involvement of remote communities in diabetes health communication programmes is facilitating the development of diabetes health promotion programmes that are consistent with remote villagers’ cultural frameworks. The fact that diabetes health promoters have adopted the WHO STEPwise approach is testament to the realization that bottom-up oral communication channels are important conduits for communicating diabetes health information to the marginalized remote villagers.

Furthermore, the involvement of remote villagers in diabetes health communication programmes by diabetes health promoters is compliant with the Diffusion of Innovation Theory. Just like the STEPwise approach, the Diffusion of Innovation framework follows a five-stage decision making process which covers: knowledge, persuasion, decision, implementation and confirmation (Rodgers and Veil 2008, p. 7). Each of these five stages recognizes target audiences as important stakeholders in the communication and decision making processes, and they emphasize the importance of community sponsored interpersonal channels of communication that would facilitate the engagement of target audiences in decision making processes. As Rodgers and Veil (2008, p. 24) assert, community sponsored channels of communication recognize the importance of the voice and language, and cultural viewpoints of target communities. On the basis of this, it can be concluded that through the recognition of these important cultural expressions, community sponsored channels are most likely to be facilitating the contextualization of diabetes health messages and making them more relevant to remote villagers.

Allied to the point about consistency with the principles of Diffusion of Innovation framework is the utilization of interactive channels of communication that enhance homophilous communication (Rodgers and Veil 2008, p. 8). The involvement of Family Welfare Educators who are members of the target communities, the engagement of key informants in the communities, and the invitation of local people who have been affected by diabetes to give oral testimonies during diabetes public health campaigns also indicate that remote villagers are demonstrably involved in diabetes campaign processes, a factor that is consistent with the principles of the Homophilous Communication Theory. The idea of having some local people propagating and leading the diffusion of diabetes health messages is consistent with Rodgers and Veil’s (2008, p. 11) assertion that health information is most trusted and best adopted by a community when it comes from a source within the same community.

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