SOCIO-CULTURAL PERSPECTIVES OF HIV/AIDS COMMUNICATION AMONGST THE BORANA PASTORALIST COMMUNITY IN ETHIOPIA

BY

DANO ENDALU OLANA

Submitted in accordance with the requirements

for the degree of

Doctor of PHILOSOPHY

In the subject

COMMUNICATION

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF C.P. CILLIERS

CO-SUPERVISOR: PROF S MOOLA

APRIL 2024

DECLARATION

Name: Dano Endalu Olana

Student number: 576-5129-9

Degree: PhD in Communication

Thesis title: Socio-Cultural Perspectives of HIV/AIDS Communication amongst the Borana Pastoralist Community in Ethiopia.

I declare that the above thesis is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references. I further declare that I submitted the thesis to originality checking software and that it falls within the accepted requirements for originality. I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other higher education institution.

25 April 2024

SIGNATURE (Mr Dano Endalu Olana) **Date**

DEDICATION

I dedicate this study to my dad, Endalu Olana Kenea, for guiding me on an education path since childhood. To my mother, Shafe Shifera Wakjira, for her tireless support and care during those bad days. To my wife, Borsena Negassa Hambissa, for her accompany, support, prayer, and carrying the family responsibility during my doctoral journey. To my lovely children, Wada, Faji, and Danga, for their patience and understanding when I was engrossed in this work (*Eebbifamaa! Guddadhaa!*). To my brother Abaya, my sisters Asabe, Dakiye, and Mulu for their prayers. To my younger sister, Bilise, for her time and devotion in taking care and supporting my children during my study. Finally, and most importantly, I give thanks to the Lord Almighty, who gave me life, strength, and the patience to realise my dream.

ACKNOWLEDGEMENTS

I gratefully acknowledge and thank the following people and institutions who assisted me in the completion of my doctoral journey:

Prof C.P. Cilliers and Prof S. Moola, my study leaders: for the tireless support, enthusiasm, guidance, constructive comments, sympathy, and insightful assistance during my study. Your continuous support and encouragement in developing the thesis components, reading all versions of the thesis, and giving valuable comments have shaped this thesis. Above all, thank you for understanding the challenges and inconveniences at home in Ethiopia during my study. Thank you, indeed!

Prof BORMAN: for her comments, together with lead supervisor, **Prof C.P. Cilliers** who shaped the title, study area, and methodology during the proposal defence in the Harmony Hotel, Addis Ababa, Ethiopia.

Ms Van Gass, UNISA: for the coordination and assistance during my study.

Mr. Adamu Birhanu, facilitator: for his ideas, support, and companion on the days that I collected field data. Thank you for sharing my pain during those days. A further special thanks to the academic staff of Ambo University, College of Medicine and Health Sciences.

Mr. Abdi Hassan: for the tireless support and coordination to collect the field data in the Borana, Arero district.

Other individuals: Dr. MitikuTeshome, Dr. Melkamu Negassa, Dr. Shilashi Badhassa, Dr. Workneh Abebe, and Dr. Atota Bedhane for their friendship, encouragement, and accompany.

University of South Africa: for the bursary to undertake this study. In addition, I duly acknowledge UNISA for allowing me the Research Output Incentive Fund (ROF1) for the English language edition.

Ambo University: for the support, research leaves permission, and understanding the challenges I faced whilst undertaking this study.

Ambo University, Department of Journalism and Communication: for considering the challenges I have been through to carry out the study.

Arero District: for allowing me to undertake the study in the district and respective kebeles.

Research participants: for their willingness, support, and tireless participation in the data collection. In conclusion, my warmest thanks are extended to friends and colleagues for their encouragement and moral support during the research process.

ABSTRACT

HIV/AIDS messages should be tailored to the specific contexts of the target community. Aspects such as the socio-cultural resources, communication dynamics, norms, and the value system of the target community determine the success of HIV/AIDS communication. The purpose of this study was to assess the socio-cultural appropriateness of HIV/AIDS communication among the pastoralist community in Borana, Ethiopia. Different health models and theories were reviewed to guide the study and qualitative case study design was used. Data was collected from the Borana pastoralist community in the Arero district using three different methods. Firstly, semi-structured interviews were held with cultural leaders, religious fathers, and healthcare workers. Secondly, focus-group interviews were held with male and female households, and lastly, a document analysis was conducted of the National HIV/AIDS policy of Ethiopia. Triangulation by means of the three methods ensured that reliable, valid, and credible data was collected. Contextual domains, like socio-cultural contexts, are considered key for effective HIV/AIDS communication in Africa. However, the findings indicated that HIV/AIDS communication among the Borana pastoralists was not tailored to the contextual domains in the local area. The communication was not appropriate to the pastoralists' realities, for example: livelihoods, mobility, droughts, and tough climate, which could hamper accessibility to HIV/AIDS messages. Traditional practices and belief systems continued to hamper the efficacy of HIV/AIDS communication. The findings also affirmed that HIV/AIDS communication disregarded the collectivist culture of Borana. The communication approach was top-down, expert-based, persuasive, urban-centred, and individual-behavioural-change oriented. As a result, this study contributed to developing a conceptual framework that considers the socio-cultural path of HIV/AIDS communication for the Borana pastoralist community. The study also pointed out that the national HIV/AIDS policy of Ethiopia — and the health system in general — needs to consider the socio-cultural contexts for the improvement of HIV/AIDS prevention among the underprivileged populations, such as the Borana pastoralist community.

Keywords: HIV/AIDS, communication, socio-cultural, religion/spirituality, gender, social behavioural change, socio-epidemiology, cultural framework, pastoralist, Borana, Arero, Ethiopia

OPSOMMING

HIV/vigs-boodskappe moet toegespits wees op die spesifieke kontekste van die teikengemeenskap. Aspekte soos die sosiokulturele hulpbronne, kommunikasie-dinamiek, norms en die waardestelsel van die teikengemeenskap bepaal die sukses van HIV/vigs kommunikasie. Die doel van hierdie studie was om die sosiokulturele gepastheid van HIV/vigs-kommunikasie onder die veeboergemeenskap in Borana, Ethiopië, te assesseer. Verskillende gesondheidsmodelle en -teorieë is hersien om die studie te lei, en 'n kwalitatiewe gevallestudie-ontwerp is gebruik. Data is ingesamel by die Borana-veeboergemeenskap in die Arero-distrik deur van drie verskillende metodes gebruik te maak. Eerstens is halfgestruktureerde onderhoude gedoen met kulturele leiers, godsdienstige vaders en gesondheidswerkers. Tweedens is fokusgroep-onderhoude gedoen met manlike en vroulike huishoudings, en laastens is 'n dokumentontleding uitgevoer van die nasionale HIV/vigs beleid in Ethiopië. Triangulasie deur middel van die drie metodes het verseker dat betroubare, geldige en geloofwaardige data ingesamel is. Kontekstuele domeine, soos sosiokulturele kontekste, word as deurslaggewend beskou vir doeltreffende HIV/vigs kommunikasie in Afrika. Die bevindings het egter aangedui dat HIV/vigs kommunikasie onder die Borana-veeboere nie toegespits is op die kontekstuele domeine in die plaaslike area nie. Die kommunikasie is nie geskik vir die veeboere se werklikhede, byvoorbeeld hulle lewensbestaan, mobiliteit, droogtes en harde klimaat nie, wat toeganklikheid van HIV/vigs-boodskappe kan belemmer. Tradisionele praktyke en geloofstelsels het die doeltreffendheid van HIV/vigs-kommunikasie bly belemmer. Die bevindings het ook bevestig dat HIV/vigs-kommunikasie die kollektivistiese kultuur van Borana verontagsaam het. Die kommunikasie-benadering was 'n afwaartse benadering, kenner gebaseerd, oortuigend, stadsgesentreerd en individueel gedragsveranderingsgeoriënteerd. Gevolglik het hierdie studie bygedra tot die ontwikkeling van 'n konseptuele raamwerk wat die sosiokulturele weg van HIV-vigs-kommunikasie vir die Borana-veeboergemeenskap in ag neem. Die studie het ook aangedui dat die nasionale HIV/vigs-beleid van Ethiopië – en die gesondheidstelsel oor die algemeen – die sosiokulturele kontekste in ag moet neem vir die verbetering van HIV-vigs-voorkoming onder die minderbevoorregte bevolkings, soos die Borana-veeboergemeenskap.

Sleutelterme: *HIV/vigs, kommunikasie, sosiokulturele, godsdiens/spiritualiteit, geslag, sosiale gedragsverandering, sosio-epidemiologie, kulturele raamwerk, veeboer, Borana, Arero, Ethiopië*

OKUCASHUNIWE

Imiyalezo ye-HIV/AIDS kufanele ihambisane nezimo ezithile zalowo mphakathi ebhekiswe kuwo. Iminxa efana nezinsiza zenhlalakahle-namasiko, izindlela zokukhulumisana, izinkambiso kanye nohlelo olubalulekile lwalowo mphakathi okubhekiswe kuwo yikho okubonisa impumelelo ekukhulumisaneni ngezinto ezithinta i-HIV/AIDS. Inhloso yalolu cwaningo bekuwukuhlola isimo esikahle senhlalakahle-namasiko ekukhumisaneni ngezinto ezithinta i-HIV/AIDS ekuhlalisaneni kwabelusi bendawo yase-Borana, e-Ethiopia. Lolu cwaningo lwenziwe ngokusebenzisa ucwaningo lokuhlola iqophelo kwabuyekezwa izindlela zezempilo ezahlukene namatiyori ukuze kuqondiswe ucwaningo. Idatha iqoqwe kusetshenziswa izindlela ezintathu ezahlukene kubelusi bendawo yase-Borana esifundeni sase-Arero. Okokuqala, kubanjwe izingxoxo kungazelele nabaholi bezamasiko, obaba bezenkolo kanye nabasebenzi bezempilo. Okwesibili, kwenziwe inhlolokhono namaqoqo okugxilwe kuwo nemindeni yabesilisa nabesifazane, kwathi ekugcineni, kwacwaningwa umbhalo wenqubomgomo ye-HIV/AIDS Kuzwelonke e-Ethiopia. Ukusebenzisa lezi zindlela ezintathu kuye kwaqinisekisa ukuthi kuqoqwa idatha ethembekile, esebenzayo, nengangabazeki. Iminxa enzulu, njengezimo zenhlalakahle-namasiko, ithathwa njengebalulekile ekukhulumisaneni ngempumelelo ngezinto ezithinta i-HIV/AIDS e-Afrika. Kodwa-ke, imiphumela ibonisa ukuthi ukukhulumisana ngezinto ezithinta i-HIV/AIDS nabelusi bendawo yase-Borana akuhambisani nezimo zendawo. Ukukhulumisana bekungahambisani nesimo esiyiso ngabantu bendawo, isibonelo, indlela yokuziphilisa, ezokuthutha/ izinto zokuhamba, isomiso, nesimo sezulu esingabekezeleki, nokungase kuphazamise ukuthi imiyalezo ye-HIV/AIDS ifinyelele emphakathini. Imikhuba yendabuko kanye nezinhlelo zezinkolelo kuqhubekile nokukhinyabeza ukusebenza kahle kwezokukhulumisana ngezinto ezithinta i-HIV/AIDS. Okutholakele kuphinde kwaqinisekisa ukuthi ukukhulumisana ngezinto ezithinta i-HIV/AIDS akuwahloniphi amasiko omphakathi wase-Borana. Indlela yokukhulumisana bekuwukutshela abantu, yenziwe ochwepheshe, ibalula izinkolelo, igxile ezintweni zasemadolobheni futhi igxile ekuguquleni ukuziphatha komuntu ngamunye. Ngenxa yalokhu, lolu cwaningo ludale ukuba kuqhanyukwe nolunye uhlaka oluzobheka indlela yenhlalakahle-namasiko ekukhulumisaneni ngezinto ezithinta i-HIV/AIDS nabelusi bendawo yase-Borana. Lolu cwaningo luphinde lwaveza ukuthi inqubomgomo ye-HIV/AIDS Kuzwelonke e-Ethiopia - kanye nohlelo lwezempilo jikelele - kudingeka ukuthi ibhekele nezimo zenhlalakahle-namasiko ukuze kuphuculwe izindlela zokuvimbela i-HIV/AIDS kubantu abampofu, njengabelusi bendawo yase-Borana.

Amagama asemqoka*: HIV/AIDS (Igciwane Lesandulela Ngculazi/ Nengculazi), ukukhulumisana, inhlalakahle-namasiko, inkolo/okomoya, ubulili, ukuguquka kokuziphatha komphakathi, isimo sezempilo emphakathini, uhlaka lwezamasiko, umelusi, e-Borana, e-Arero, e-Ethiopia*

AXEERARA

Ergaan HIV/AIDS kallattiin haala jiruufi jireenya hawaasichaan wal simachuu qaba. Milkaa'ina komunikeeshinii ittisa HIV/AIDS ilaalchisee kanneen murteessoo ta'an: aadaafi hawaasummaa, koorniyaa, amantaa, tooftaalee komunikeeshinii, sirna safuufi duudhaalee haawaasichaa fa'i. Dhimmi qorannoo kanaa Komunikeeshiniin ittisa HIV/AIDS naannoo horsiisee bulaa Booranaa haalota aadaafi hawaasummaa, koorniyaa, amantaa, jiruufi jireenya hawaasichaan wal simachuu isaa adda baasuudha. Qorannoo kana geggeessuuf sakattaan akkayyaawwaniifi yaadximoota komunikeeshinii fayyaarratti xiyyeeffatan taasifameera. Qorannoon kun akaakuu qorannoo akkamtaa kan hordofe yoo ta'u, mala qorannoo dhimqoo irratti kan hundaa'eedha. Ragaaleen qorannoo kanaa horsiisee bulaa Booranaa, Araddaa Areeroo, keessaa funaaname.Ragaaleen kunniinis tooftaalee adda addaa sadiin kan funaanaman yoo ta'u isaanis: af-gaaffii xiyyeeffannaa (abbootii Gadaa, dursaalee amantiifi ogeessota fayyaa), af-gaaffii marii garee xiyyeeffannaa (abbootii manaafi haadholii) fi xiinxala kuufata Imaammata HIV/AIDS Itoophiyaadha.Tooftaalee sadeen kunniin qulqul'ina, haqummaafi amanamummaa ragaalee qorannoo mirkaneessaniiru. Biyyoota Afriikaa keessatti, dhukkuba HIV/AIDS ittisuuf haalonni aadaafi hawaasummaa murteesoodha. Haa ta'u malee, argannoon qorannoo kanaa kan mul'isu, komunikeeshiniin ittisa HIV/AIDS haalota horsiisee bulaa Booranaan kan wal simate miti. Haalonni dhaqqabiinsa ergaa ugguruu danda'an kanneen akka jiruufi jireenya horsiisee bulaa, godaansa /sochii, hongee, haalli ho'a qilleensaa ilaalcha keessa kan gale miti. Barmaatileefi ilaalchotni hawaasa keessa jiran milkaa'ina komunikeeshinii ittisa HIV/AIDS danqaniiru. Komunikeeshiniin ittisa HIV/AIDS aadaa waliin jireenya Booranaa ilaalcha keessa kan galche miti. Komunikeeshiniin ittisa HIV/AIDS naannoo horsiisee bulaa Booranaa keessatti adeemsifamaa ture olii-gara gadii, ogeessarratti kan rarra'e, amansiisuurratti kan xiyyeeffate, magaalaa giddu-gala kan taasifate, akkasumas jijjiirraa amala nama dhuunfaarratti kan rarra'eedha. Haaluma kanaan, qorannoon kun kominikeeshinii ittisa HIV/AIDS caaya yaad-rimee aadaafi hawaasummaa bu'uureeffate horsiisee bulaa Booranaaf gumaacheera. Imaammanni HIV/AIDS fi sirni fayyaa Itoophiyaa haalota aadaafi hawaasummaa hawaasa dagatamaniif, kanneen akka horsiisee bulaa Booranaaf, xiyyeeffannoo addaa kennuu akka qabu qorannoon kun akeekeera. Kanaaf, komunikeeshiniin ittisa HIV/AIDS naannoo horsiisee bulaa Booranaa haalota aadaafi hawaasummaa, amantaa, koorniyaafi malleen komunikeeshinii naannoo horsiisee bulaan wal simachuu qaba.

Jechoota Ijoo: *HIV/AIDS, Kominikeeshinii, aadaafi hawaasummaa, amantii/afuura, koorniyaa, jijjiirraa amala hawaasaa, saayinsii dhibeefi hawaasummaa, daangeffama aadaa, horsiisee bulaa, Boorana, Areeroo, Itoophiyaa*

TABLE OF CONTENTS

APPENDICES

LIST OF FIGURES

LIST OF TABLES

CHAPTER 1

INTRODUCTION

1.1 INTRODUCTION

HIV/AIDS is a major global health challenge (Klionsky et al 2021). In 2021, 38.4 million people were living with HIV globally, two-thirds of whom were living in sub-Saharan Africa. This puts Africa at the centre of the HIV pandemic (United Nations Programme on HIV and AIDS (UNAIDS) 2022). Reducing the burden of the HIV infection is not only imperative to the general population, but particularly in populations at high risk of acquiring HIV (UNAIDS 2022). The UNAIDS (2022) report shows most people with HIV are in low- and middle-income countries. “In 2021, there were 20.6 million people living with HIV (53%) in eastern and southern Africa, five million (13%) in western and central Africa, six million (15%) in Asia and the Pacific, and over two million (5%) in western and central Europe and North America” (UNAIDS 2022:27).

HIV/AIDS continues to affect human lives in Africa (Seyedet al 2021). The global Millennium of Development Goals (MDG) aimed to reduce the occurrence of HIV/AIDS by 50% by 2015 (UN 2015). Regional and international organisations have been working to combat the spread of the epidemic. It is therefore crucial to consider the factors that influence HIV/AIDS communication and to design appropriate intervention strategies (Bashir et al 2019). However, HIV/AIDS programmes in Africa have been critiqued for not addressing the context of the epidemic, instead relying upon generalised approaches. The subject of HIV/AIDS prevention in public discourse in sub-Saharan Africa is often focused on the epidemiological aspect of HIV/AIDS prevention, which overlooked the contextual factors in the target community (Stewart 2014). Unprotected sexual intercourse has fuelled the spread of HIV/AIDS in Ethiopia (Mirkuzie et al 2021; Endalamaw et al 2020; Katbi et al 2018). HIV/AIDS interventions have been intensified since the launch of the Millennium Development Goal. The burden of HIV/AIDS remains high in Ethiopia, despite a considerable scale-up of HIV/AIDS interventions (Deribew et al 2019:850). According to Girum, Wasie, and Worku (2018) Ethiopia adapted the global 90-90-90 HIV prevention target by 2020, which is part of a strategy designed to eliminate the HIV/AIDS epidemic by 2030. In this study, Girum, Wasie and Worku (2018:4) reported that by 2020, 90% of all people living with HIV were supposed to know their HIV status, 90% of all people diagnosed with the HIV

infection were supposed to receive sustained antiretroviral therapy, and 90% of all people receiving antiretroviral therapy were supposed to have viral suppression. However, despite Ethiopia's remarkable progress, HIV continues to be a major public health issue.

FHAPCO strategic plan of 2021-2025 reveals that the Ethiopian HIV/AIDS epidemic is characterized as mixed, with wide regional variations and concentrations in urban areas, including some distinct hotspot areas driven by key and priority populations. The National adult (15-49) HIV prevalence is 0.93% in 2019; prevalence in women constitutes 61% of infections (women 1.22%, men 0.64%). There are wide regional variations ranging from a high in Gambella at 4.5%, Addis Ababa at 3.42% with the lowest in Somali region at 0.01%. In 2019, the national HIV incidence rate in the adult population is estimated at 0.02% (0.03% in females and 0.02% in males) with an estimated 15,000 (9,000 females and 6,000 males) new infections, the majority (67%) of these occurring in the age group below 30 years. About 265 out of more than 1000 districts in the country constitute nearly two thirds of all new infections annually. FHAPCO 2021-2025 indicates that with an estimated 669,000 people living with HIV (PLHIV) of which 39,792 are<15 years of age, HIV remains a heavy burden on the country (FHAPCO 2021-2025).

Vulnerability to the HIV infection is a major concern affecting the control of HIV/AIDS in Borana (Serbessa2019:12). Developmental communication approaches, including HIV/AIDS prevention, should not only consider the macro domains at national level, which includes the economy and politics. Attention should also be given to the micro contexts in the community such as culture, religion/spirituality, and gender (Rogers et al 2021). HIV/AIDS communication can only be effective when it takes the socio-cultural factors into consideration (Rogers et al 2019; WHO2016; Adeodataet al 2013). However, the socio-cultural approaches to HIV and AIDS communication among the pastoral settings of Ethiopia, like the Borana pastoralists, were not well documented. Individuals from mobile communities, like the Borana pastoralists, are more likely to fall outside of the routine HIV surveillance system (Rogers et al 2019:2; WHO2016). Furthermore, studies revealed that little is known about the effectiveness of context-based HIV/AIDS interventions in pastoral settings (Rogers et al 2019:2). The evidence indicating the relationship between socio-cultural contexts and the use of health services in pastoral settings is dearth (Zepro et al 2023; Kinaro et al 2018). As a result, this study focused on exploring the socio-cultural aspects of HIV/AIDS communication among the Borana pastoralist community. More specifically, this study aimed to explore the integration of HIV/AIDS communication with the

community-specific contextual domains such as culture, religion/spirituality, gender, and communication of the Borana pastoralists in Ethiopia.

The first focus of this study was to assess the appropriateness of HIV/AIDS communication to the socio-cultural context of the community. The conceptual contribution of this study challenges the epidemiological, top-down, western-oriented individual behavioural change communication theories and models that overlook the socio-epidemiological aspects of HIV/AIDS prevention. It peers into the social behavioural change and collectivist cultural society of developing countries such as Borana, Ethiopia. As the findings of this study revealed: HIV/AIDS communication for the Borana pastoralists overlooked their unique features, such as their livelihoods (see Chapters 6and 7). The communication approaches were influenced by the western-based behavioural change theories and models which undermined the collectivist culture of the pastoral community. This study therefore plays a significant role in assessing the socio-cultural appropriateness of HIV/AIDS communication among the underprivileged, marginalised, and culturally bound Borana pastoralist community in Borana, Ethiopia (Kaba 2022; Gammino et al 2020; Kinaro et al 2018). The findings of this study (see Chapter 9) contribute to the design of contextualised HIV/AIDS communication approaches that consider the specific contexts of the pastoral community. It corroborates the fact that HIV/AIDS communication in the Borana pastoralist community should consider contextual factors (Gari et al 2013). In addition, HIV/AIDS programmes should understand the collectivist culture of the target community for effective message delivery and social behavioural change (Bashir2019:4-5).

The second focus of this study was to explore the practices (behavioural changes) among the Borana pastoralist community in line with the community-based HIV/AIDS communication. Behavioural Change Communication (BCC) is a proven health communication strategy used to promote positive behaviours and practices for diseases like HIV/AIDS (Akuiyibo et al 2022; Belay et al 2022; Bhatta, Liabsuetrakul, & McNeil 2017). Public health and health behaviour interventions in Africa should focus on culture to achieve meaningful and sustainable change, resulting in positive health outcomes (Airhihenbuwa, Ford, & Iwelunmor 2014).

Lastly, this study focused on understanding HIV/AIDS communication approaches that suited the lifestyle and contexts of the underprivileged, marginalised, culturally bound Borana pastoralist community.

HIV/AIDS communication in Africa focuses on the urban communities and less on the rural areas (Kolié, Van De Pas, & Codjia 2023; Asresie, Worku & Bekele 2023; Maulide 2021).

In the rural community of sub-Saharan Africa, the HIV/AIDS communication approach did not adequately consider the nature of the target community (Durosinmi-Etti et al 2021). HIV/AIDS prevention facilities and communication in Ethiopia to date had focused on the urban situations, overlooking the populous, underprivileged, and marginalised rural communities such as the pastoralists. However, research evidence shows that the HIV/AIDS epidemic in rural areas of Ethiopia is expanding to the unknown areas, such as the rural community (Asresie, Worku & Bekele 2023; Deribew et al 2019; Tamiru et al 2011; Bekalu & Eggermont 2013).

There are different underpinnings realities that motivated the researcher to undertake this study. There are limited studies concerning the HIV/AIDS situation in the rural areas of Ethiopia (Asresie, Worku & Bekele 2023; Habte et al 2022; Mirkuzie et al 2021). In the Ethiopian HIV/AIDS prevention target of 2030, emphasis is given to the epidemiological aspect of disease prevention, which overlooked the socio-cultural aspects of HIV/AIDS prevention. The third Sustainable Development Goal of Ethiopia (SDG-3) aims to end the epidemic of HIV/AIDS by 2030 (Project 2030), based on the lessons learned during the last two decades. However, HIV prevention requires a paradigm shift, from a vertical response to an integrated health systems response, to provide services according to societal needs and contexts (Assefa & Gilks 2020). The main driver of the HIV/AIDS epidemic in Ethiopia was thought to be unprotected sexual practices. The epidemiological aspect of HIV/AIDS prevention was given emphasis over the contextual domains that determine the effectiveness of HIV/AIDS prevention in a culturally bound community like the Borana pastoralists (Mirkuzie et al 2021; Girum et al 2018). In the collectivist Ethiopian cultural group, overlooking the socio-cultural context of HIV/AIDS prevention affects the national efforts to curb the spread of the epidemic. HIV/AIDS communication in Ethiopia needs to consider the cultural context of the target community that shape their societal behaviours. The communication approaches should be participatory. However, the findings of this study revealed that HIV/AIDS communication with the Borana pastoralist community is top-down, formal, expert-oriented, persuasive, and gender-biased. It further overlooked the significance of the Indigenous context and the cultural path of inclusive communication for effective social behavioural change (see Chapter 6).

1.2 PURPOSE AND CONTEXTUALISATION

In sub-Saharan Africa, the HIV/AIDS prevention messages in countries like Ethiopia have included the promotion of partner education and focusing on the epidemiological aspects (Jones, Salazar, Crosby 2017;Butler et al 2016;Airhihenbuwa, Ford, &Iwelunmor 2014; Iwelunmor, Newsome, &Airhihenbuwa 2014).Literature works in the past did not adequately address issues like sexual debut, alternatives to risky sex, mutually faithful monogamy, consistent and proper use of condoms, better recognition of sexually transmitted disease symptoms, and effective health-seeking behaviour(Baraki & Thupayagale-Tshweneagae 2023; Gamarel, King, & Operario 2022;Cornell et al 2021:38; Dubé 2019; Tadesse & Yakob 2015). Numerous interventions are being implemented throughout Africa, but many are still information-based health Information, Education, and Communication (IEC) (Cornell et al 2021:38). HIV/AIDS communication focused on the general population group which overlooked the specific needs of the rural community. There is a lack of innovative HIV/AIDS communication approaches that consider the contextual factors of the rural community in sub-Saharan Africa (Cornell et al 2021:39).

Sub-Saharan African countries are geographically, demographically, socially, and culturally heterogeneous (Cornell et al 2021). Similarly, the extent and spread of HIV/AIDS in Africa have been heterogeneous and therefore requires country-specific communication approaches (Cornell et al 2021). This requires contextualised approaches that consider the local domains that either accelerates or decelerates the spread of HIV/AIDS in the region. In the context of this study, thus, the research was interested to assess the embedment of HIV/AIDS communication into the contextual domains like culture, religion/spirituality, and gender in the Borana pastoralist community of Ethiopia. It further explored the practices among the Borana pastoralist community that affects the community-based HIV/AIDS IEC. In addition, the relevance of the national HIV/AIDS policy of Ethiopia to the contexts of the marginalised, underprivileged, culturally bound, mobile pastoralists were examined in line with the objectives of the study. Lastly, insight is provided into pastoralist-friendly HIV/AIDS communication approaches that accommodates the realities of the pastoral culture.

1.2.1 The context of the spread of HIV/AIDS in Ethiopia

Ethiopia is one of the sub-Saharan African countries seriously affected by the HIV/AIDS epidemic (Ministry of Health 2002; UNAIDS 2000).

The burden of HIV/AIDS remains high in Ethiopia, despite the HIV/AIDS intervention initiatives (FMOH 2015). Deribew et al (2019:859) claims that the number of new HIV infections in Ethiopia was higher in 2016 than in 2010. In addition, the Addis Standard News Magazine report (October 6, 2017) reveals that HIV/AIDS is surging in Ethiopia again. This means HIV incidence is on the rise (Mirkuzie et al 2021). The Ethiopian Public Health Institute report shows that there are over 603,537 people living with HIV in Ethiopia (May 2023). Globally, there is a consensus that if the total number of HIV-infected people in each country is more than one percent, the country would fall under the category of outbreak of the virus (Addis Standard News Magazine October 6, 2017). HIV/AIDS remains an obstacle to the multifaceted developments in Ethiopia (World Bank 2020). The Federal HIV/AIDS Prevention and Control Office (FHAPCO) (2011:30) reported that a lack of a comprehensive and coordinated communication framework challenged the campaigns against the HIV/AIDS epidemic in Ethiopia.

The UNAIDS report (2023) affirms that there is a significant increase in the number of sexual partners in some African countries such as Ethiopia. It indicates that this country's social behaviour, specifically sexual behaviour, can contribute to the spread of HIV/AIDS. There is a need to address certain social behaviours that would have negative effects on the country's attempt to tackle HIV/AIDS challenges. The National Reproductive Health Strategy of Ethiopia (2005–2015) highlighted that in many rural areas of Ethiopia, Behavioural Change Communication (BCC) activities are viewed as urban-focused and not locally relevant to the context of rural communities such as the pastoralists. There is a lack of coordination in HIV/AIDS service provision.

In addition, there is no uniformity between the urban and rural population's health service coverage to curb the spread of HIV/AIDS (Kolié, Van de Pas &Codjia 2023; Asresie, Worku &Bekele 2023; Maulide et al 2021). Linkages between stakeholders and public activities are especially limited and HIV/AIDS is not sufficiently integrated into the contextual domains of the target community. Despite the on-going service delivery efforts, the needs of the rural population, such as the pastoralists, with HIV/AIDS are not sufficiently met. HIV/AIDS communication did not address many of the socio-cultural factors that underlie greater risks. These factors include polygamy, widow inheritance, early marriage, female genital mutilation (FGM), and other related gender-based abuses. HIV/AIDS prevention strategies focused on an epidemiological study (Jeffries & Henny 2019). However, HIV/AIDS prevention that is only based on the medical intervention cannot fully explain the disparities in the prevalence of HIV/AIDS among gender, communities, regions, and countries (Jeffries & Henny 2019).

Therefore, there is a need to address the social-cultural, religious/spiritual, and gender contexts in communicating HIV/AIDS messages to bring about the desired change.

The FHAPCO report (2014) indicated that the multispectral strategic plan to control HIV/AIDS prevalence is comprehensive and has been tested effectively in other African countries. However, it faces major challenges in Ethiopia because of the current socio-economic, cultural, and political environments which are important for effective HIV/AIDS prevention. Lack of a health infrastructure is also likely to impede the implementation of HIV/AIDS programmes. In addition, traditionally disadvantaged populations in the remote rural areas, such as the pastoralists, are more at risk due to poor health infrastructure and staffing problems. These include skills and knowledge gaps, as well as staff turnover (Rogers et al 2021).

HIV/AIDS continues to be subjected to misunderstanding and several misinformed opinions. It is imperative to grasp how the correct (or incorrect) information could add to individual behavioural changes (Seid & Ahmed 2020:441). Regardless of all the behavioural modification efforts to reduce HIV transmission, misreading information and myths remain a vital influence on risky sexual behaviours (Seid & Ahmed 2020:441). People's understanding about HIV/AIDS and the efficacy of condom use is not adequate in Ethiopia. According to Habte et al (2022) the urban residents in Ethiopia remain significantly better informed about HIV than the rural residents. HIV/AIDS knowledge, attitudes, and practices among the rural population are limited. This is due to the poor health services, poor socio-economic status, long-lasting traditional practices and beliefs, and inadequate exposure to contextualised HIV/AIDS information, education, and communication (FHAPCO 2014). This implies that HIV/AIDS in rural Ethiopia is not properly embedded within the local socio-cultural, religious/spiritual, and gender contexts of the target community. Research on HIV/AIDS in the past could not provide satisfactory answers to the questions why individuals engage in unsafe sexual practices and how these practices are reinforced and maintained by the social, cultural, religious, and spiritual conditions of the society (Kairania, Onyango-Ouma & Ondicho 2023; Vitsupakorn, Pierce, &Ritchwood 2023; Belle & Gamedze 2019). Furthermore, Ethiopian health communication is not well contextualised into the local cultural realities (Marissa et al 2013:8).

1.2.2 HIV/AIDS scenarios in the pastoralist community of Ethiopia

According to Abduselam (2019:17) pastoralism is not only a culture, but also a livelihood system that extensively uses the rangelands. It is also the key production system practised in the arid and semi-arid dry land areas. This research dealt with the socio-cultural perspectives of HIV/AIDS communication among the underprivileged, marginalised, and culturally bound pastoralist community in Borana, Ethiopia. The viewpoints of non-urban, non-sedentary demographics, such as pastoralists in Africa, have been marginalised which undermines the use of Indigenous resources (Rogers et al 2021). In the context of Africa, health services have focused more on the urban residents (Rogers et al 2021; Waters-Bayer, Birmeji& Mengistu2005). Health services and research are expanded into the rural areas of the highlands. Urban professionals and politicians play intermediary roles between the rural communities and development actors (Rogers et al 2021). Pastoralists usually reside in the lowland areas of Ethiopia. The outreach of social services such as education and health in these pastoralist areas is low. Similarly, there has been little outreach in terms of HIV/AIDS prevention control activities and care (Waters-Bayer, Birmeji& Mengistu 2005:1). Pastoral communities are characterised by low access to reproductive health services (Der Kwaak et al 2012).

In these pastoral areas of Ethiopia, there are no adequate a study on HIV/AIDS (Serbessa 2019:69; Mela Research2014; Waters-Bayer, Birmeji& Mengistu 2005). Insufficient attention is being given to the marginalised and poor regions in the pastoralist areas of Ethiopia (WHO 2018). HIV/AIDS communication in the pastoralist community of Ethiopia is not well contextualised. The communication did not adequately consider the specific realities in the pastoralist community (Rogers et al 2021). Specificities of pastoral life could make the pastoralists susceptible to the rapid spread of HIV/AIDS once it is introduced because of their source of livelihood: mobile livestock production system (Waters-Bayer, Birmeji & Mengistu 2005:2). HIV/AIDS IEC should be combined with the efforts to maintain social cohesion and promote effective and contextualised messages.

1.2.3 A brief background of the research site and research community

The Oromo are the largest single ethnic nation in eastern Africa, constituting more than 40% of the Ethiopian population (Legesse 1973). The Oromo people speak Afan Oromo. The language of Oromo belongs to the eastern Cushitic family of Afro-Asiatic phylum.

Afan Oromo is one of the most widely spoken languages in Africa, surpassed only by Arabic and Housa Fulani (Hordofa 2001; Muudee 1995). Outside Ethiopia, the language is spoken by thousands of other Oromo tribes in Kenya and beyond.

Borana Oromo is a senior Oromo clan. The Borana Oromo occupies the Borana zone of the southern Oromia arid area along Ethiopia's borders with Somalia and Northern Kenya. The Borana zone has 14 administrative districts. The national population census indicated that the total Borana population is estimated over one million. The Borana community's economic life depends on livestock. The Borana community that is situated in the lowland areas are known as pastoralists. They are best known for maintaining the Indigenous socio-cultural resources such as the *Gadaa* system. The *Gadaa* system is the socio-cultural and political system of the traditional Oromo society. In Borana, the formal governance is operating in parallel with that of the traditional *Gadaa* system (Serbessa et al 2016:1). "The Borana's oral history suggests that the *Gadaa* system of polity has been in practice since the early 13thcentury and is still in effect among the Borana pastoral community" (Serbessa et al 2016:1-2). Afan Oromo is the native langue of the Borana people.

The pastoralist community in Borana was chosen to study the cultural approach to HIV/AIDS communication. The research was conducted in the Arero district of Borana. This is because the Arero district is the centre for the Borana cultural institutions and practices like the *Gadaa* institution. The Borana pastoralists are vulnerable to HIV infections due to their involvement in unsafe sexual practices (Serbessa et al 2016). HIV/AIDS interventions in Borana focused on the approaches of generic behavioural changes, such as abstinence, extramarital sexual practices' perceived association with HIV infection, faithfulness, and condom use. However, abstinence and faithfulness are not adequately practised in Borana and therefore doesn't aid in the prevention of HIV/AIDS (Serbessa et al 2016:27). This indicates that there is a need for designing HIV/AIDS interventions that take the local context into account. HIV is a major threat in Borana with individual- and community-level consequences. Extramarital sexual practices, men's role in the selling of livestock, and consequent encounters with other women facilitate vulnerability to HIV (Serbessa 2019). In the Borana pastoral community, having multiple sexual partners is culturally recognised through *Jaala-Jaaltoo* sexual networks. Men may have several sexual partners and women may have sexual partners other than their husbands. Extramarital sexual practices are not only related to sexual desire, but also to the fulfilment of gender roles and the social expectation of being wanted. The extramarital sexual relation is also believed to strengthen economic exchanges between the individuals involved and sometimes reach the extended

families. Discussing sexual matters in the public sphere is culturally taboo and not considered a social norm for the Borana (Serbessa 2019). This is because the community abides by the norms, values, and principles set by the cultural institutions like the *Gadaa* institution. The matter of the cultural acceptability of extramarital sexual practices requires further study in Borana (Serbessa et al 2016:25–26). Apart from the epidemiological interventions, expert-based and knowledge-oriented HIV/AIDS IEC, HIV/AIDS communication approaches in Borana should consider the socio-cultural context and the livelihoods of the target community in Borana. The cultural models, health communication models, and theories concerning HIV/AIDS prevention are discussed in detail in Chapter 3, Part II.

1.2.4 The importance of the cultural approach to HIV/AIDS prevention

Culture and HIV/AIDS in sub-Saharan Africa are linked by a tangled web of associations that are difficult to isolate (Sovran 2013:34). Culture plays a vital role in determining the level of health of the individual, the family, and the community (Airhihenbuwa& Webster 2004). This, together with the rules of sexual conduct, shapes the community's knowledge and beliefs (Achen, Atekyereza, & Rwabukwali 2021:25). Focusing on culture to address HIV/AIDS messages is particularly applicable in the context of the Borana pastoralist, where the values of extended family and community influence the behaviour of individuals (Achen, Atekyereza & Rwabukwali 2021). The behaviour of the individual in relation to family and community is one major cultural factor that has implications for sexual behaviour and HIV/AIDS prevention (Airhihenbuwa & Webster 2004:4).

As the impact of HIV/AIDS in sub-Saharan Africa remains persistent, a culture-centred approach to prevention, care, and support is increasingly recognised as a critical strategy (Uwah 2013). Culture should be preserved and utilised for positive development, including HIV/AIDS prevention in Africa. "If culture is the totality of life for a particular group of people, it stands to reason that in Africa, culture and health are intertwined" (Uwah 2013:27). This means the problems of HIV/AIDS cannot be addressed if the prevention and communication approach overlook the cultural domains of the target community in Africa.

Vulnerability to HIV infection is a major concern among the pastoral settings in Ethiopia (Kaba 2022). The pastoralist community, such as the Borana pastoralists in Ethiopia, are among the underprivileged, marginalised population groups, suffering under the influence of

harmful cultural practices. Harmful practices like violence against women (rape, abduction, and domestic violence), early marriage, widow inheritance, FGM, ear piercing, and extramarital sexual practices are widespread in many parts of Ethiopia (Mtenga et al 2018; Ramjee & Daniels 2013). The findings of this study also indicated that there are harmful practices in the Borana pastoralist community that hampered the effectiveness of HIV/AIDS communication (see Chapter 6 and 7). The use of traditional medicine and faith healing, which is not yet scientifically proven, is practised in the rural community of Ethiopia and may contribute to HIV/AIDS problems (Shiferaw et al 2020; Haile et al 2017; Ramjee & Daniels 2013). In addition, deep-rooted sexual behaviour, poverty, and gender inequities contribute to the spread of HIV/AIDS (UNAIDS 2022).

HIV/AIDS communication among the Borana pastoralist community overlooked the Indigenous socio-cultural, religious/spiritual, and gender contexts for effective pastoralist-friendly communication (Serbessa 2019). HIV/AIDS communication approaches need to integrate the cultural elements into the intended messages. Making HIV/AIDS communication culturally acceptable and relevant, as well as promoting culturally integrated communication strategies would enhance HIV/AIDS IEC (UNAIDS 2022:10). As the findings of this thesis indicate (see Chapter 6and 7), HIV/AIDS communication among the Borana pastoralists should cater to the contextual domains such as culture, religion/spirituality, gender, and user-friendly communication (see Chapter 9). The importance of a cultural approach to health communication in general (as well as HIV/AIDS communication) is discussed in detail in Chapter 3 Part I and Part II.

1.3 THE RATIONALE FOR THE STUDY

The rationale for this study is explained by a need for the cultural embedment of HIV/AIDS communication among the pastoralist community in Borana, Ethiopia. The seriousness of HIV/AIDS risks, and the lack of contextualised communication among the underprivileged, marginalised, and culturally bound Borana pastoralists, further justified this study (Rogers et al 2021; Kaba 2019; Mtenga et al 2018; Kaba Ame &Mariam 2013). It is imperative that HIV/AIDS messages need to address the cultural domains of the target community (UNAIDS 2000). In the context of this study, the Borana society has long-lasting cultural practices, norms, and values that would help fight the HIV/AIDS epidemic, if wisely utilised. This means there are Indigenous socio-cultural institutions like *Gadaa* and *Gumii Gaayyoo* that would

help shape societal health behaviour. Unfortunately, there are also traditional cultural practices that would fuel the spread of the HIV/AIDS epidemic in Borana.

The Borana Zone Health Department (2000) reported that the spread of HIV/AIDS in Borana is the result of complicated socio-cultural, economic, and political activities of the past. Sexual topics are considered taboo in different cultural groups in African countries (Mtenga et al 2018). This is also applicable to the Borana pastoralist community where the topic of sex is taboo within the community (see Chapter 6). Research findings in Ethiopia are mostly urban centred and draws attention away from the rural areas where the severity is not on the public agenda (Feyasa, Gebre, & Dadi 2022; Abate et al 2018; Bekalu &Eggermont2014; Bekalu & Eggermont 2013). Unless due attention is given, the near future might be even more devastating in the infected areas of the urban community of the highlanders, as the infection rate is already high (Rogers et al 2021).

HIV/AIDS, as an intricate problem, calls for a complex trans-disciplinary, communicative development approach (Rogers et al 2021). The communicative approach should consider the issue of culture for the specific social group (Lie 2008:4). It is not well-known that culture and traditions are the most important determinants of health behaviour in a developing country such as Ethiopia. Cultural resources are given little attention (Marmot & Wilkinson 2005:23). Thus, taking culture into account when it comes to HIV/AIDS prevention, creates level of participatory approaches that genuinely meet people where they are, and work with them to address the aspects of their life that they identify as important. The socio-cultural engagement in HIV/AIDS prevention would create the space for the target community to reflect on their own health situation, using the Indigenous approaches (Khandu, Tobgay & McFarland 2020; Hofstede & Minkov 2010).

1.4 PURPOSE OF THE STUDY

The aim of this study was to assess the socio-cultural appropriateness of HIV/AIDS communication among the pastoralist community in Borana, Ethiopia. The study intended to address culturally embedded HIV/AIDS communication that caters to the local context of the targeted Borana pastoralist community. The study is about applied communication. It is with this argument that contextualised communication plays a crucial role in all areas of development, including societal health (Rogers et al 2021; Du Plooy & Du Plooy 2009:50).

As such, the application of communication to address HIV/AIDS messages needs scientific research when taking the target community into consideration.

1.5 FORMULATION OF RESEARCH OBJECTIVES AND QUESTIONS

In the sections that follow, the general and specific research objectives as well as the basic research questions are set out.

1.5.1 General research objective

HIV/AIDS remains a challenge in Ethiopia (Klionsky et al 2021; Mirkuzie et al 2021; Deribew et al 2019; Serbessa 2019). The prevention of the spread of HIV/AIDS in the underprivileged and marginalised rural areas of Ethiopia is inadequate as the prevention and communication strategies had overlooked the contextual domains of the specific community. The communication models and theories used to curb the spread of HIV/AIDS were borrowed from the western individualistic behavioural models of disease prevention, which did not consider the realities of the collectivist cultural society in African countries, such as Ethiopia.

1.5.1.1 Specific objectives

- To explore the socio-cultural embedment of HIV/AIDS communication among the pastoralist community in Borana, Ethiopia.
- To explore/understand the perspectives and social behavioural change practices among the Borana pastoralist community in relation to the community-based HIV/AIDS communication.
- To identify ways in which HIV/AIDS communication approaches consider the specific contexts of the pastoral community in Borana, Ethiopia.
- To describe the socio-cultural embedment in the HIV/AIDS policy of Ethiopia in the context of a pastoralist community, such as the Borana pastoralist community in Ethiopia.

1.5.2 Research question

What is the situation of HIV/AIDS communication among the Borana pastoralist community in Ethiopia when considering the contextual domains such as culture, religion/spirituality, gender, and user-friendly communication approaches?

1.5.2.1 Specific research questions

- Does HIV/AIDS communication among the Borana pastoralists address the socio-cultural domains such as culture, religion/spirituality, and gender?
- What are the social behavioural change practices among the Borana pastoralists in relation to the community-based HIV/AIDS communication?
- What is considered acceptable and culturally appropriate HIV/AIDS communication approaches for the Borana pastoralist community?
- Does the HIV/AIDS policy of Ethiopia address the socio-cultural context of the Borana pastoralist community?

1.6 STATEMENT OF THE PROBLEM

This study explores the socio-cultural perspectives of HIV/AIDS communication among the pastoralist community in Borana, Arero district, Ethiopia, via a qualitative cross-sectional case study, using in-depth interviews (storytelling), focus group interviews, and document analysis. Effective communication is a key factor in presenting HIV/AIDS messages and prevention campaigns, and delivering treatment programmes in diversified culture of Africa (Wang & Shi 2019). Communication scholars have long emphasized the need to recognize adherence to socio- cultural contexts of target communities as catalyst for effective HIV/AIDS communication. Unfortunately, this call has not adequately been considered by the designers of HIV/AIDS communication instruments in Africa (Uwah 2013). In the context of thesis study, HIV/AIDS communication focussed on the general population which disregarded the specific interests and contexts in the local areas. The specific nature of the target community such as their pastoral livelihoods, mobility, livestock marketing, droughts, and climate change challenges were unnoticed in the HIV/AIDS communication efforts. To date, HIV/AIDS research and literature works in Ethiopia were urban centric and focused on the epidemiological aspects of disease prevention.

It did not effectively consider the socio-cultural perspectives of HIV/AIDS prevention in the most remote rural contexts, like the Borana pastoralists. Studies indicate that HIV/AIDS communication should address the contextual domains of the specific population group (Rogers et al 2021; Kaba 2019; Mtenga et al 2018; Kaba, Ame & Mariam 2013; Uwah 2013). HIV responses need to be tailored specifically for the key populations, instead of the current generalised approaches used in sub-Saharan Africa (Khandu, Tobgay& McFarland 2020).
There is a need to present HIV/AIDS messages in the cultural paradigm and Indigenous contexts (Uwah 2019). However, HIV/AIDS prevention in Ethiopia overlooked the specificities and contexts of the rural areas (Habte et al 2022). The communication approaches overlook the key Indigenous domains in the local areas. HIV/AIDS communication in the culturally bound community of the developing countries tend to be top-down, authoritarian, and unidirectional, characterised by vague warnings rather than direct, open discussions because of the deeply rooted socio-cultural contexts (Mtenga et al 2016). Accordingly, health programmes and facilities among the pastoral communities in Ethiopia remain relatively weak, with mounting concern (Kaba 2019).There has been marginalisation of the viewpoints of non-urban, non-sedentary demographics, such as the pastoralists, which undermines the use of local contexts (Rogers et al 2021).Vulnerability to HIV among the Borana pastoral community is facilitated by multiple factors (Kaba 2019).There is an urgent need to assess whether the existing HIV/AIDS communication among the pastoralist community in the Arero district of Borana, Ethiopia, are tailored towards the communication needs, culture, religion/spirituality, gender roles, expectations, norms, and value system of the specific community.

1.6.1 Identifying the gap

HIV/AIDS knowledge, perceptions, and attitudinal change in the Borana pastoral community remain low on average (Kaba 2019). HIV/AIDS communication approaches failed to consider the socio-cultural dimensions and the lifestyle of the Borana pastoralists (Rogers et al 2021; Serbessa et al 2016). Vulnerability to the epidemic is increased by multiple socio-cultural, religious/spiritual and gender factors that call for contextualised communication (Kaba 2019). The Indigenous socio-cultural resources in the Borana pastoralist community that would promote effective HIV/AIDS campaigns were not properly utilised (Kaba 2022; Kaba 2019; FHAPCO 2014; Serbessa et al 2016; Waters-Bayer, Birmeji& Mengistu2005; Hussein 2004). The communication approaches and message designs to date were not in tune with the cultural realities of the target pastoral community (FHAPCO 2014:19).

HIV/AIDS communication focused on blaming harmful practices, rather than using the positive Indigenous resources for effective HIV/AIDS communication.

In addition, the health services were not effectively tailored towards the specific needs, culture, traditions, beliefs, norms, and value system of the rural pastoralist community (Khandu, Tobgay & McFarland 2020). The public health system and HIV/AIDS policy of Ethiopia did not adequately address the unique lifestyle of the pastoralist population. Pastoralist communities have often been politically and economically marginalised in state policy in sub-Saharan Africa countries (Herrera, Davies, & Baena2014:4). These existing gaps, thus, motivated the researcher to undertake the study on the specific topic. Therefore, this study addresses the gaps through assessing the socio-cultural appropriateness of HIV/AIDS communication among the Borana pastoralist community in Borana, Ethiopia.

Generally, HIV/AIDS awareness in the Borana pastoral community remains low due to inadequate communication strategies that fail to consider the socio-cultural characteristics and lifestyles of the local community. Multiple factors contribute to the community's vulnerability to the epidemic, necessitating contextualised communication. Indigenous resources in the community were underutilised, and communication approaches like BCC were out of step. Health treatments were not tailored to the pastoralist community's unique requirements. As a result, this study contributes to the development of Borana pastoralist-friendly conceptual framework that considers the contextual domains for effective HIV/AIDS communication. The study also contributes to the limited literature concerning pastoralist-specific socio-cultural perspectives of HIV/AIDS communication that would pave the way to shape the national HIV/AIDS policy to accommodate the pastoralist realities in Ethiopia.

1.7 RELEVANCE OF THE STUDY

HIV/AIDS issues were not adequately addressed in rural areas of Ethiopia. Research on the HIV/AIDS epidemic had focused on urban residents only. In Ethiopia, not only prevalence or incidence data is lacking, but there has been little research to describe the dynamics of the spread of the disease under rural communities, or behavioural studies (Serbessa et al 2016). The research findings on HIV prevalence in rural areas are still conflicting. The high numbers of new HIV infections, which is concentrated among the underprivileged population groups, needs urgent intervention (FHAPCO 2018:26). Western-originated health communication models and theories are insufficient to bring social behavioural change when it comes to

HIV/AIDS in the context of the collectivist pastoral culture in Ethiopia (Mapingure, Mukandavire& Chingombe 2021). Hence, there is a need for a dynamic shift in HIV/AIDS communication that should consider the socio-cultural aspects of the specific population (Rogers 2021; Khandu, Tobgay & McFarland 2021; Mabweazara, Ley & Leach 2018).

1.8 THE RELATION OF THIS TOPIC TO THE FIELD OF COMMUNICATION

HIV/AIDS communication often integrates components of multiple theories and models to promote positive changes in the community. The cultural approach to HIV/AIDS-related work allows prevention efforts not to rely on the biomedical concepts as means of prevention (Airhihenbuwa et al 2009). There is a need to present HIV/AIDS messages in the cultural paradigm and Indigenous contexts (Uwah 2019). It is essential to utilise the Indigenous knowledge systems for sustainable and appropriate health programmes and prevention efforts (Uwah 2019, 2013). Interdisciplinary research and collaborations that consider the local contexts are crucial to address HIV/AIDS messages effectively in Africa (Willems 2009). Therefore, as a socially complex problem, HIV/AIDS prevention requires the participation of stakeholders from different occupations. The epidemic is both a biomedical disease and a social phenomenon that requires the multi-stakeholder's cooperation (Mabweazara, Ley & Leach 2018).

1.9 LIMITATIONS OF THE STUDY

The qualitative case study research design is limited as the findings cannot be generalised with reference to all pastoralists and non-pastoralists communities in other areas of Oromia, Ethiopia. However, the use of a case study site in the Borana zone, and the number of participants, made it possible to collect relevant in-depth information concerning the socio-cultural appropriateness of HIV/AIDS communication among the Borana pastoralist community (Creswell & Creswell 2017). The security problems and Covid-19 pandemic highly affected the study's duration. The researcher was not able to collect the necessary data on time because of the intricate security challenges in the region and the sudden emerging Corona virus that limited movement. There has been armed conflict in the local areas and the surrounding community for the last five years.

1.10 CHAPTER DEMARCATION

In Chapter 1, research issues and the context of the study are introduced. Chapter2 provides a detailed explanation of the context of HIV/AIDS in Africa, Ethiopia, and Borana. Chapter 3, Part I provides detail about health communication, health promotion, and the socio-cultural aspects of health communication. Chapter3, Part II provides detailed information on HIV/AIDS communication models and theories in relation to their relevance to the context of the developing countries such as Ethiopia. Diverse cultural and health models and theories were reviewed and critiqued in this chapter, pointing out the gaps while acknowledging culturally tailored HIV/AIDS communication approaches. Chapter 4 presents the conceptual framework developed from literature as a contribution for this study and emphasises tailored HIV/AIDS communication that consider the contextual domains such as culture, religion/spirituality, gender, and user-friendly communication to curb the spread of HIV/AIDS among the Borana pastoralist community. Chapter 5 deals with the methodology selected for the study. The qualitative case study research design adheres to Yin's (2014; 2009), Creswell and Creswell's (2017) and Eisenhardt's (1989) case study research. This chapter includes the data analysis, data interpretation, triangulation, and the aspects of reliability and validity used to justify the case study conducted. Chapter 6 presents the findings from the in-depth interviews. Chapter 7 presents the findings from the focus group interviews. Chapter 8 presents the findings from the analysis of the national HIV/AIDS policy of Ethiopia. Chapter 9 concludes the study and explains how the research objectives of the study were achieved. Recommendations, policy implications, as well as future research directions were indicated in this chapter. The following section presents operational definitions and/or explanations in the context of this study.

1.11 OPERATIONAL DEFINITIONS OF THE CONCEPTS AND/OR TERMINOLOGIES

An operational definition is crucial to clarify the following concepts and/or terminologies:

- ***Abbaa Gadaa***

Abbaa Gadaa, or the head of *Gadaa*, is elected democratically from among the *Gadaa* age grade. *Gadaa* is where political, social, military, and ritual leadership is exercised in Borana. The *Abbaa Gadaa* serves the people for eight years as a leader and spokesperson of the assembly (Jalata 2012: 35).

- ***Bokkuu* (“knob, club”)**

Bokkuu is a designed wooden sceptre from the olive tree in the Borana Oromo tradition. It is a sign of office and is surrounded by a spiritual atmosphere. *Hayyuu* (judges) and members of the *warra bokkuu* (people of the *Boku*) might carry it as a sign of ritual and judicial power (Appiah & Gates 2010:28).

- **Borana**

The Borana, also called the Boran, is a major Oromo clan who lives in southern Ethiopia (Oromia) and northern Kenya. The Borana people are known for their historic *Gadaa* political system. The Borana speak Afan Oromo, which is part of the Cushitic branch of the large Afro-Asiatic language family (Appiah & Gates 2010:20).

- **Communication context**

Context in communication refers to the way that communication is given meaning. It is essential for effective communication. Factors like the physical location and characteristics, the culture associated with the communicators, the relationships between communicators, and the expected behaviour based on past behaviours can influence the context (Shah, McLeod & Yoon2001).

- **Communication strategy**

Communication strategy is the practice of using tailored, targeted information related to a specific issue, event, situation, or audience. It serves as the blueprint for communicating with the public, stakeholders, or even colleagues to achieve a certain communication goal (Olaoye & Onyenankeya 2023:10).

- **Contextual factors**

Contextual factors are a range of factors that can influence health, safety, well-being, and participation in physical activity. These factors include personal, social, cultural, economic, and political factors that exist in different ways and have varying impacts across population groups (Cook et al 2023).

- **Cultural context**

For this research, cultural context is related to the Borana society in Ethiopia where individuals are raised and represents how the culture affects behaviour. It incorporates values that are learned and attitudes that are shared among groups of people. These include beliefs, meanings, customs, ideas, language, and norms (Raeff et al 2020).

- **Culture of Borana**

The culture of Borana is an umbrella term which encompasses the social behaviours, institutions, and norms found in Borana, as well as their knowledge, beliefs, arts, laws, customs, capabilities, and habits. Borana culture (in this context) is a set of distinctive spiritual, material, intellectual, and emotional features of the social group that encompasses not only art and literature, but also lifestyles, ways of living together, value systems, traditions, and beliefs (UNESCO 2001). As such, "the Borana culture includes codes of manners, dress, language, religion, and means of livelihoods (pastoralism), rituals, art, gender roles and expectations, norms of behaviours such as law and morality, and systems of belief" (Raeff et al 2020:295).

- **Culture vis-à-vis tradition**

Culture is the collective term to identify certain ideas, customs, and social behaviours. It represents a group of people or a society, combining their knowledge, beliefs, morals, and laws. Tradition, on the other hand, is a more specific term including ideas and beliefs passed down from one generation to the next. Culture provides shared meanings and values, while tradition manifests in day-to-day (Rangel 2022).

- ***Gadaa***

"*Gadaa* (literally meaning era) is the Indigenous democratic system of governance used by the Oromo in Ethiopia and northern Kenya. The system regulates the political, economic, social, and religious activities of the community" (Ta'a 2004). "Under *Gadaa*, every eight years, the Oromo would choose by consensus nine leaders known as *Salgan yaa'ii Borana* (the nine Borana assemblies). A leader elected by the *Gadaa* system remains in power only for eight years, with an election taking place at the end of those eight years (Jalata 2012:127).

- **Gender**

Gender is the social attributes and opportunities associated with being male or female, and the relationships between women and men, girls and boys, as well as the relations between women and those between men (Keogh 2021). "The term gender context is used to refer to both the individual's and society's gender-based thoughts, feelings, and behaviours, as well as the sex- and gender-based interpersonal interactions people have" (Keogh 2021:23).

- ***GumiiGaayyoo***

The Borana Oromo speak of *Gumi-Gayo* (*Gumi* means assembly and *Gayo* refers to a water well). Among the central Oromo, *Gumi Gayo* is called *Chaffee* (meaning assembly at the edge of prairie grass), while among the *Guji-Oromo*, it is known as *Yaa'iiMe'ee-Bokuu* (*Yaa'ii* meaning multitude and *Me'ee-Boku*meaning - Me'ee-Boku refers to the place participant where every person can attend the Gadaa general assembly) (Sima 2015:6).

- **Health Communication**

Health communication is a multifaceted and multidisciplinary field of research, theory, and practice concerned with reaching different population groups to exchange health-related information, ideas, and methods in order to influence, engage, empower, and support individuals, communities, healthcare professionals, patients, policymakers, organisations, special groups, and the public so that they will champion, introduce, adopt, or sustain a health or social behaviour, practice, or policy that will ultimately improve individual, community, and public health outcomes (Schiavo, May Leung, & Brown 2014).

- **Integrated marketing communication**

Integrated marketing communication is a communication strategy employing market promotion models to ensure that all forms of communication are linked together and working in harmony to address a given behaviour (Behnampour et al 2021).

- ***Kebele***

Kebele is the smallest administrative unit of Ethiopia: a ward, a neighbourhood, or a localised and delimited group of people.

- ***Odaa***

Odaa is the most respected and the most sacred tree. The shade of the *Odaa* tree is revered as a source of tranquillity. The shade of the *Odaa* tree is both the central office of the *Gadaa* government where the *Gadaa* assembly meet, as well as a sacred place for ritual practices. *Odaa* became a socio-political centre for the Oromo people (Legesse 2000:25).

- **Pastoralists**

Pastoralists are communities who practise pastoralism as a major livelihood system. Livestock production systems are normally practised in dry land areas (Schoof & Luick 2018).

- ***Qaalluu***

Qaalluu is an important institution in the Oromo religious and social system to protect the Oromo culture and tradition. *Qaalluu* means pure, holy, sacred, blameless, and black (Appiah & Gates 2010:45).

- **Religious context**

Religion is a range of social-cultural systems, including designated behaviours and practices, morals, beliefs, worldviews, texts, sanctified places, prophecies, ethics, or

organisations. Religions are deeply embedded in cultural practices and institutions, as well as artistic expression (Arrey et al 2016:4).

- **Religious father**

In the context of this study, religious father is to mean spiritual father (Kgatle 2023).

- **Social marketing**

Social marketing is a marketing approach which focuses on influencing behaviour with the primary goal of achieving common good. It utilises the elements of commercial marketing and applies them to social concepts (Behnampour, Shams, Hassanzadeh, Ghaffarian Shirazi, Naderi, & Kariminejad 2021).

- **Spiritual context**

Spiritual context is the way in which people understand and live their lives considering their ultimate beliefs and values. It is the unifying and integrative aspect of a person's life and, when lived intentionally, is experienced as a process of growth and maturity (Fowler & Peterson 1997).

- ***Waaqaa***

Waaqaa is an Indigenous Oromo religion (Martial 2005). The word *Waaqeffanna* derives from the word *Waaqaa*, which is the ancient name for the Creator in the Cushitic languages of both the Oromo people and Somali people in the Horn of Africa (Abdullahi 2001:3). The followers of the *Waaqeffanna* religion are called *Waaqeffataa* and they believe in *Waaqa Tokkicha* (one God).

1.12 CONCLUSION

This study focused on tailoring HIV/AIDS communication to the contextual domains in the Borana pastoral community, Ethiopia. Chapter 1 reviewed the overall contexts, rationale, purpose, relevance, objectives, scope, contribution, definitions of important terminologies, and chapter demarcation of this research. Chapter 2 provides further context by explaining the essence of health communication in general as well as HIV/AIDS communication specifically. The change in health communication from the epidemiological orientation to the socio-epidemiological aspects was discussed in Chapter 2. Moreover, factors determining health communication, the rationale for cultural health integration, and the importance of health message design for specific populations are discussed in the following chapter.

CHAPTER 2

THE CONTEXT OF HIV/AIDS IN AFRICA, ETHIOPIA, BORANA

2.1 INTRODUCTION

This chapter highlights the HIV/AIDS situation in the context of the World, Africa, and Ethiopia. In addition, HIV/AIDS issues are discussed from the perspective of the pastoral culture in general and, more specifically, the Borana pastoralist community in Ethiopia. The chapter presents the global spread of HIV/AIDS, HIV/AIDS in Ethiopian context, HIV/AIDS situations in the study site, risks of HIV/AIDS, population groups that are vulnerable to HIV/AIDS, practices fuelling the spread of HIV/AIDS, and a community-specific approach to alleviate to problems of HIV/AIDS.

2.2 GLOBAL SPREAD OF HIV/AIDS

The joint United Nations Programme on HIV/AIDS report from2022 indicated that 38.4 million people across the globe were infected with HIV (UNAIDS 2022). “Of these, 36.7 million were adults and 1.7 million were children (<15 years old). In addition, 54% were women and girls” (UNAIDS 2022:2-4). The UNAIDS report (2022) indicates that “an estimated 1.5 million individuals worldwide contracted HIV in 2021, while around 650,000 people died from AIDS-related illnesses worldwide”. Most people living with HIV are in low- and middle-income countries. The international UNAIDS report (2022) emphasised that HIV/AIDS is a growing concern for the world. The next topic highlights the specific HIV/AIDS scenario in Africa.

According to the World Health Organisation (WHO) report (2023), HIV remains a major global public health issue, having claimed 40.4 million (32.9–51.3 million) lives so far, with on-going transmission in all countries globally. In line with this, the WHO report indicates that new HIV incidences are observed in some developing countries like sub-Saharan Africa (WHO 2023). Almost like the 2022 report, the report of 2023 indicates that there were an estimated 39.0 million (33.1–45.7 million) people living with HIV at the end of 2022, two thirds of whom (25.6 million) are in the African region (WHO 2023).

According to the report in 2022, 630,000 (480,000–880,000) people died from HIV-related causes and 1.3 million (1.0–1.7 million) people acquired HIV. UNAIDS has set a goal to end the AIDS epidemic by 2030(UNAIDS 2018). To achieve this goal, UNAIDS requires that by 2020, 90% of people living with HIV (PLWH) should know their HIV status, 90% of individuals diagnosed as PLWH should receive sustained antiretroviral therapy (ART), and 90% of those who received ART should have their blood viral load suppressed (90-90-90 strategy) (Loncar, Izazola-Licea, & Krishnakumar 2023). Programmes and measures for patient-centred ART in general, and at-risk population-centred preventions have been proposed to reduce HIV transmission through all possible ways, including sexual contact, needle sharing, and vertical maternal-child transmission (Loncar, Izazola-Licea & Krishnakumar 2023).

Despite advances in the scientific understanding of HIV, its prevention and treatment, as well as years of significant effort by the global health community, the leading government and civil society organisations, poor countries of the global south still grapple with the problems of HIV/AIDS (Loncar, Izazola-Licea & Krishnakumar 2023). The HIV epidemic not only affects the health of individuals, but also impacts households, communities, and the development and economic growth of nations. Many of the disadvantaged, and specifically the economically-disadvantaged, population in the developing countries hardest hit by HIV also suffer from other infectious diseases, food insecurity, and other serious problems (Global Health Policy 2023; WHO 2018). This implies that HIV/AIDS is still a global threat, especially for the developing nations, which requires collaborative and country-specific interventions.

The HIV/AIDS epidemic has highlighted the global nature of human health, welfare, and globalisation. It has given rise to a call for common solutions to global health challenges (Global Health Policy 2023). Numerous international funds have been set up in recent times to address global health challenges (WHO 2018). However, despite increasingly large amounts of funding for health initiatives being made available to poorer regions of the world, HIV infection rates and prevalence continue to increase worldwide (WHO 2018). The epidemiology of HIV/AIDS differs between regions (WHO 2018). There are dissimilar patterns of sexual behaviour among the world population that require tailored intervention strategies that accommodate the context of the target population. The regions affected by the HIV/AIDS epidemic are undoubtedly the poorer regions of the world as combinations of poverty, disease, and famine, political and economic instability; along with weak health infrastructure exacerbate the severe and far-reaching impacts of the epidemic (Mbengo et al

2022). It is vital to ensure an equitable balance between prevention and treatment programmes to holistically address the challenges presented by the epidemic. However, despite concerted efforts to curb the HIV epidemic, disparities in response are evident among countries, geographical locations, populations, and communities. HIV/AIDS communication should consider the people in various geographical locations and environmental strains like the pastoral community. This would help to develop population-specific HIV/AIDS interventions that promote effective and contextualised services.

HIV prevention interventions by reducing risky sexual behaviours can be classified as structural, behavioural, or combined (Mbengo et al 2022). Structural interventions aim to reduce risky sexual behaviour by addressing structural-level factors such as poverty, unemployment, limited access to education, and social norms (Muthoni et al2020; Hosek & Pettifor 2019; Pettifor et al 2013). The behavioural interventions facilitate risky sexual behaviour reduction by targeting individual-level factors such as knowledge, attitudes, self-esteem, and self-efficacy. The combined interventions reduce risky sexual behaviour by addressing one or more individual-level factors, as well as one or more structural-level factors (Muthoni et al 2020; Hosek &Pettifor 2019; Pettifor et al 2013). However, structural and behavioural interventions that overlook the collectivist culture of the developing countries are ineffective to curb the spread of HIV/AIDS.

Pastoralist communities, including the African pastoralists, are among the underprivileged, marginalised, and culturally bound population. There has been marginalisation of the viewpoints of non-urban and non-sedentary demographics, such as the pastoralists in Africa, which undermines the input of local opinion leaders as well as Indigenous resources (Rogers et al 2021). Pastoralist communities have often been politically and economically marginalised in state policy (Pavanello 2009), which makes participatory processes especially difficult (Herrera, Davies & Baena 2014: 4). Insufficient attention is still being given to the marginalised and poor pastoralist regions in Africa (WHO 2018) Pastoral communities are characterised by low access to reproductive health services (Van der Kwaak et al 2012). In the context of this study, HIV/AIDS-related research focusing on pastoral communities in the Intergovernmental Authority on Development (IGAD) countries, were found to be limited in scope and coverage and revealed precarious situations (Serbessa et al 2016). HIV/AIDS interventions in the pastoralist regions of East Africa, such as Borana, were not well contextualised and integrated into the needs of those impoverished populations as well as national HIV/AIDS programmes (Serbessa et al 2016). Various literatures concerning HIV/AIDS prevention indicate that the epidemiological aspect of the epidemic is given

emphasis. HIV/AIDS prevention strategies in developing countries like Ethiopia focused on the macro contexts such as the economy and national politics. The micro contexts, such as culture, are overlooked in the fight to combat the spread of HIV/AIDS. To effectively curb the problems of HIV/AIDS, the socio-cultural aspects of each country in the world should be considered. HIV/AIDS in the context of Africa is highlighted in the next section.

2.3 HIV/AIDS IN AFRICA

HIV/AIDS remains a threat to global public health, disproportionately affecting countries across sub-Saharan Africa. Although treatment and access to care have improved, prevention remains critical to end new HIV infections by 2030 (Rapaportet al 2023:150). The UNAIDS report (2022) indicated that in 2021, there were “20.6 million (53%) people with HIV in eastern and southern Africa, 5 million (13%) in western and central Africa, 6 million (15%) in Asia and the Pacific, and 2.3 million (5%) in western and central Europe and North America”. The UNAIDS global reports (2002, 2000 & 1998) also revealed that the HIV infection has been increasing in some developing regions (UNAIDS 2002). The report reveals that the struggle against the HIV/AIDS epidemic requires further efforts, especially among the sub-Saharan African countries. The population groups who lead challenging lives are at greater risk in terms of the HIV/AIDS epidemic. UNAIDS data (UNAIDS 2016:1) shows both the enormous gain already made and the challenges ahead concerning the HIV/AIDS epidemic in developing countries. Developing countries display high rates of HIV/AIDS, with Africa in the lead (UNAIDS 2013:8).

Trends in new HIV/AIDS infections differ among African regions. Trends in AIDS-related deaths in sub-Saharan Africa show that there has been an increase in deaths due to HIV/AIDS (UNAIDS 2018:28). Countries across sub-Saharan Africa are disproportionally affected by HIV, recording more than 70% of the global burden (USAID 2018). Among the 20.7 million PLWH in Sub-Saharan Africa, 73% of adults and 58% of children are on antiretroviral therapy (Rapaport et al 2023). Despite improving access to this therapy in addition to improved testing, HIV incidence in sub-Saharan Africa continues to rise, necessitating improved prevention efforts (USAID 2018). From the past, as well as the recent empirical evidence, sub-Saharan African countries are where the challenges of the HIV/AIDS epidemic still require urgent intervention. East Africa is one of the regions where risky sexual behaviour has been contributing to the expansion of the HIV/AIDS epidemic. For instance, extramarital sexual relations have been fuelling the spread of HIV/AIDS in some

African countries such as Burkina Faso, Congo, Cote d'Ivoire, Ethiopia, Gabon, Guyana, Rwanda, South Africa, Uganda, the United Republic of Tanzania, and Zimbabwe (UNAIDS 2013:14). There is a need to study certain socio-cultural behaviours and county-specific issues to address HIV/AIDS messages (UNAIDS 2013:14).

In sub-Saharan Africa, a variety of HIV/AIDS prevention strategies exist, yet their effectiveness is difficult to measure and varies due to the nature of the interventions and vulnerability of the intervention during implementation. Most of the HIV/AIDS prevention strategies depend on medial epidemiology which overlooks the contextual domains in the local areas. HIV prevention interventions should represent large-scale multi-sector public health initiatives that are best employed utilising a local population approach, which centres programmes on collaborations between governments, local civil society organisations, and local communities (Rapaport et al 2023:150). HIV/AIDS prevention needs to include integrative approaches that consider the specificities in the local areas (UNAIDS 2016). Yet, real-world evaluations are challenged by the difficulty in quantifying the efficacy of any single intervention within a health programme and large gaps exist in measuring the sustainability and accessibility of programmes (UNAIDS 2016). In sub-Saharan Africa, HIV/AIDS monitoring and evaluation strategies focus predominantly on process outputs, while the effectiveness and impact have traditionally been more challenging to measure. In addition, the heterogeneity of affected populations in sub-Saharan Africa requires locally tailored solutions (Rapaport et al 2023).

It is important to understand that HIV/AIDS is both a biomedical disease and a social phenomenon that is constructed in specific cultural contexts (Mabweazara, Ley & Leach 2018). Medical services alone cannot address the problems of HIV/AIDS in the culturally bound sub-Saharan African countries like Ethiopia. Individual lifestyles, the working environment, and cultural determinants are intertwined and influence each other, resulting in increased risk behaviour and create more complex structural barriers for testing and treatment among key populations in sub-Saharan Africa (Khandu, Tobgay & McFarland 2020). Social and cultural values, norms, and traditions influence individual lifestyles and behaviours of the population affected by HIV/AIDS prevention (Khandu, Tobgay & McFarland 2020). The evidence also shows a paradigm shift from considering HIV/STIs as an individual concern, to larger policy and social structural factors (Mabweazara, Ley & Leach 2018). Reluctance within the sub-Saharan Africa community to promote or engage in open discussions about the impact of HIV was identified as a key barrier to effective prevention.

Additionally, shame surrounding discussions about HIV appeared to be closely linked to cultural inhibitions concerning any discourse on sex (Both, Etsub & Moyer 2013). HIV/AIDS policies should consider the contextual factors operating within economic, political, and social spheres of the respective countries (Edwards & Barker 2014).

2.3.1 HIV/AIDS in Ethiopia

Ethiopia is one of the countries well-known for having an HIV epidemic fuelled by unprotected sexual intercourse, like many other East African countries (Mirkuzie et al 2021). Currently, with an adult HIV prevalence of 0.9%, Ethiopia has joined the group of countries who struggle with a concentrated epidemic (Mirkuzie et al 2021). This implies that HIV/AIDS remains the main health concern in Ethiopia. Although reducing HIV prevalence and incidence rates are big successes for the county, currently tracking new infection has presented a challenge as reflected by the poor progress made to achieve the first 90% target (Mirkuzie et al 2021:2). It requires extra effort to identify the highest contributors of these new HIV infections, groups that carry the highest burden, and infected individuals who otherwise would have been missed by the existing system. The Addis Standard News Magazine report (2017) reveals that HIV/AIDS is surging again in Ethiopia. The report emphasised that there were over 718,550 people living with HIV in Ethiopia alone, a little over 1.18% of the population. According to the globally accepted consensus, “if the total number of HIV infected people in a given country exceeds the one per cent threshold of the population, that country falls under the category of an outbreak of the virus” (Mirkuzie et al 2021). The 2016 Ethiopian Demographic Health Survey (DHS) reveals that there was a poor culture of testing for HIV/AIDS in Ethiopia. The survey results show that despite the existence of a considerable number of people living with HIV/AIDS, only 72% of them were aware that they were living with the virus; the remaining 28% thought that they were not infected. In addition, the FHAPCO report (2017) indicates that “27,288 people were known to have been infected by HIV during the 2009 Ethiopian calendar; 16,021 (59%) were women whereas 11,267 (41%) were men”. The report further stated that among the three million pregnant women who were receiving medical follow ups, around 27,000 of them were HIV positive. It is possible to deduce from the reports that the problem of HIV/AIDS in Ethiopia still requires critical attention and effort. Ethiopia requires an adequate and inclusive strategy to combat HIV/AIDS (Serbessa et al 2016). The approaches to address HIV/AIDS issues in Ethiopia did not consider the native contexts in the local areas (Airhihenbuwa& Webster 2004).

Ethiopia is committed to achieving the Millennium Development Goal of averting HIV/AIDS. However, the existing evidence shows that the country must still work on solving the multifaceted problems of HIV/AIDS.FHAPCO (2010:6) reported that, with an estimated 1.1 million people living with HIV, Ethiopia has a large part of their population infected with HIV. Ethiopia's HIV/AIDS epidemic pattern continues to be generalised and heterogeneous with marked regional variations. HIV prevalence is declining in urban areas (FHAPCO 2010:7). However, HIV/AIDS occurrence has been increasing in smaller market towns in Ethiopia. "Commercial sex workers, uniformed services, long-distance truck drivers, refugees and displaced people, daily labourers, mobile/migrant labourers, including cross-border population, street children, high school and university students, out-of-school youth and Indigenous populations in remote foreign destinations are all involved in transactional sex" (FHAPCO 2010:8).Gender inequalities, early marriage, polygamy, widow inheritance, and drug use were among the factors fuelling the spread of HIV/AIDS in Ethiopia (FHAPCO 2010:29). Gender inequality leads to gender-based violence that exposes women to the risks of HIV/AIDS in Ethiopia. Government reports also indicated that divorced, separated, and widowed women were the most affected by sexual violence in Ethiopia (Addis Standard News Magazine 2017).

In Ethiopia, substance abuse like alcohol and khat increases the likelihood of having multiple sexual partnerships (FHAPCO 2010). Abebe et al (2005:174-181) explain that traditionally, the khat plant (Catha endulis) has been used for both medicinal and recreational reasons. Now, the buds and leaves of this plant are chewed for their stimulant and euphoric effects. As khat contains chemicals called cathinone and cathine, it works as a stimulant that speeds up the way the brain and body talk to each other (Abebe et al 2005 174-181). The population group who uses alcohol and khat are about twice as likely to have multiple sexual partners as those who are not using drug substances. In a study by Abebe et al (2005:174-181) they found that people with HIV who eats khat while drinking alcohol and having casual sex are more likely than the control group to do things that put them at risk of contracting HIV. Using alcohol and khat together has its own impact on properly using condoms to protect against HIV (FHAPCO 2010:29). In Ethiopia, women, people in the remotest areas, migrants, sex workers, long-distance drivers, and drug users demand special consideration in the campaign against HIV/AIDS. HIV/AIDS communication should consider the effect of polygamy, drug use, gender abuse, widow inheritance, and the high divorce rate that could contribute to the spread of the epidemic. In the context of this study, HIV/AIDS communication among the Borana pastoral community, Ethiopia, should consider the contextual domains and life experiences of the pastoral community.

The communication should address the agrarian-pastoral, rural-urban gaps in user-specific messages that is relevant to the demographical and geographical characteristics of the target population. The next topic presents the HIV/AIDS strategic plan of Ethiopia.

2.3.1.1 HIV/AIDS strategic communication plan of Ethiopia

The government of Ethiopia demonstrated commitment to the prevention and control of HIV/AIDS and the expansion of reproductive health services (FHAPCO 2010). National HIV/AIDS policy and different strategies have been developed to tackle the challenges. For instance, the HIV/AIDS strategic plan of 2015–2020, in an Investment Case Approach by FHAPCO (2014:11), have set four major strategic objectives to prevent HIV/AIDS. These objectives were to implement high impact and targeted prevention programmes, to intensify targeted HIV testing and counselling services, to attain virtual elimination of mother to child transmutation (MTCT), and optimising and sustaining quality care and treatment. FHAPCO (2014) emphasised that behavioural change communication is crucial to implement high impact disease prevention. The BCC was targeted to bring about the intended behavioural change among at-risk populations and priority geographical areas.

HIV/AIDS programmes in Ethiopia to date focused on some segments of the population who were assumed susceptible to the risks of HIV/AIDS, like female sex workers, long-distance truck drivers, urban and hotspot area dwellers, and students in schools (FHAPCO 2014:12). Strengthening school HIV education, increasing community-based HIV/AIDSBCC, through the health extension and health development army, empowering communities, and sustaining the gains were major areas of concern. In addition, sustainable and equitable condom distribution and use was among the focal points to prevent the HIV/AIDS epidemic in the country. Young female sex workers, vulnerable women, truck drivers, daily labourers in development sectors, and uniformed forces were given emphasis in the HIV/AIDS programmes. The HIV/AIDS strategic plan of Ethiopia 2015–2020 underlined that behaviour change communication, structural prevention strategy, the distribution and use of condoms, HIV testing, and counselling were among the HIV/AIDS prevention strategies that should be considered (FHAPCO 2014). However, the plan to address HIV/AIDS through BCC did not consider the Indigenous socio-cultural contexts in the local community. HIV/AIDS in Ethiopia require innovative prevention strategies (Addis Standard Magazine October 6, 2017). The government plan should consider communication approaches such as social BCC to alleviate the risks of the epidemic.

2.3.1.2 Health behavioural change communication in Ethiopian context

BCC is an interactive process aimed at effectively changing behaviours (Weston &Amlôt 2020). In Ethiopia, behavioural change communication material for HIV/AIDS focused on disseminating medical messages that outlined ways of HIV transmission and protection against the disease (HAPCO 2009). “The BCC materials gave minimum attention to the cultural and social contexts, which highly influence the effectiveness of the behavioural change communication initiatives” (HAPCO 2009:7). In the context of HIV/AIDS, “BCC forms an essential component of a comprehensive programme that includes prevention services (medical, social, psychological, spiritual), and commodities (condoms, needles, and syringes)” (HAPCO 2009). The BCC process should consider that individuals and communities pass through several stages when learning about new behaviours before subsequently adopting them. However, it is argued that individuals and communities must understand the basic facts about HIV/AIDS, develop favourable attitudes toward prevention, learn a set of skills, and have access to appropriate products and services before they are able to reduce its impact or change their attitude towards the epidemic. Individuals and communities should also perceive their environments as supportive of the change (FHAPCO 2009).

FHAPCO (2009) indicated that Ethiopia developed a national communication framework that employs a broad range of IECBCC and advocacy activities, approaches, and diverse communication channels. The framework defined five domains: government policy, socio-economic status, culture, gender relations, and spirituality that need to be considered when developing communication materials for HIV/AIDS to encourage behavioural change (HAPCO 2009). Considering the findings of this study, a national communication framework seemed critical. However, the framework focused on the government policy, which gives priority to the macro domains like economy and politics. Secondly, BCC that uses IEC materials were criticised for focusing on the knowledge domain, which is one of the drawbacks of the cognitive-oriented behavioural models and theories. The IEC focused on formal communication materials that are more suitable for the literate groups. The material preparation lacks adequate involvement from the local population and local resources, such as culture. Moreover, the behaviour change communication, as it originates from western behavioural change models and theories, focuses on individual behavioural change. The effectiveness of the BCC in Ethiopia was not studied and evaluated in the context of an underprivileged, marginalised, and culturally bound local community in Ethiopia, like the

pastoralist community in Borana. Socio-cultural elements were not embedded within the HIV/AIDS communication among the pastoral Borana. The BCC programme for Ethiopia has critical gaps. These gaps include inadequate coverage of the programme, limitation of the programme in some locations, poor coordination and weak implementation capabilities, as well as large-scale development schemes that have no capacity to implement the programme (FHAPCO 2014:32).

In Ethiopia, promoting condom use has been a mechanism to prevent HIV/AIDS (Tofu et al 2023). A great proportion of condoms are distributed through the social marketing approach of condom promotion using different outlets such as pharmacies, drug stores, hotels, bars, and kiosks. Condoms have also been distributed through health facilities, mega projects, and NGOs/community-based organisations. This accounted for one fourth of the annually distributed condoms. The main recipients of the free condoms were STI cases, work forces in the development schemes, truck drivers, and female sex workers.

Condom social marketing is a type of intervention in which condom brands are developed, marketed with a promotional campaign, and sold to a specific target population. Condom social marketing is one approach to increase condom availability and use; other approaches include public/free and private distribution of condoms (Sweat et al 2019). Condom social marketing has historically been a mainstay of HIV public health interventions (Sweat et al 2019).In Ethiopia; the FHAPCO report (2014) stated that condom promotion through social marketing was one of the ways to prevent HIV/AIDS. There were however critical challenges in condom distribution and use (Tofu et al 2023; Gebeyehu, Chanko, &Yesigat 2020). The existing gaps were “lack of unified coordination and integration of efforts of actors involved in condom distribution, low condom coverage, knowledge gaps in the quantification of universal condom needs, as well as inconsistent condom use among sex workers. In addition, there is an incomplete understanding of the condom preferences of the target group, as well as lack of clarity on what should be the condom outlet in different sectors” (FHAPCO 2014:36). However, FHAPCO (2014) evaluated behavioural change communication more from the knowledge and attitude domains. The contribution of socio-cultural factors for BCC effectiveness was not adequately observed in the context of developing countries like Ethiopia.

The social learning/cognitive theories of disease prevention, the behaviour change communication model, the information, education, and communication approach, as well as social marketing theories to promote condom distribution and use were given due emphasis

in HIV/AIDS prevention in Ethiopia (FHAPCO 2014).However, HIV/AIDS prevention frameworks among the mobile, culturally bound, disadvantaged population groups like the Borana pastoralists were not properly addressed in the national policy document. Pastoralist communities generally live in isolated, remote, and underdeveloped areas. These areas are often conflict prone, known for having food insecurities, and associated with high levels of vulnerability. Service provision in pastoral areas is usually less developed than in other areas, with lower health and education indicators than national-level figures. The behaviour change communication in practise in Ethiopia was urban centred. The BCC and IEC models were taken from the western disease prevention approaches.

Western health models and theories focused on scientifically justified and pre-defined behavioural changes (Cuevas & O'Brien 2017; Spencer 2014). The educated community of the western countries has access to scientific information. However, the scenario in a developing region, like Ethiopia, is quite different. Western health models and theories need to be integrated into the contexts of the local community in Ethiopia. Western health models and theories should consider the Indigenous contexts in the developing countries like Ethiopia. One of these contexts is the socio-cultural context. Therefore, HIV/AIDS communication models and theories in practise within Ethiopia must be tailored to the socio-cultural contexts in the local community. This study accepts the HIV/AIDS communication shift from purely biomedical, psychological, social cognition models to the culturally based models and theories to design programmes and interventions for HIV/AIDS prevention. The next section explains HIV/AIDS in the context of the African pastoralists (Kelly-Hanku et al 2020; Lazuardi et al 2019; Tumwine, Aggleton & Bell 2019).

2.4 PASTORALISM AND HIV/AIDS IN AFRICA

The worldwide literature on pastoralism is extremely uneven and determined by socioeconomic, culture and political issues related with pastoral communities, as well as by the need of empirical data availability. Based on limited available knowledge of pastoralism, different Organizations and Scholars define pastoralism in different ways. FAO defines as "extensive livestock production in the pastures". The United Nation Convention No. 169(1989) defined as "ethnic identity, Indigenous and Tribal Peoples". Pastoralism scientifically defined as "A member of social groups with a strong traditional association with livestock keeping, where a substantially proportion of the group derive over 50% of the household consumption from livestock products or their sales, and where over 90% of animal consumption is from natural pasture, and where members of the households are

responsible for the full cycle of the livestock breeding". Pastoralism may be thought as a system in a range of livestock and non-livestock activities connect through a web of social and economic relationships that extend well beyond lowland areas to highland economies and across the nation's borders (Lind & Kohnstamm 2016). However, in this study for simplicity, pastoralists are defined as livestock keepers who depend almost exclusively on livestock for their livelihood and are characterized by some degree of mobility within pastoralist ethnic groups.

Pastoralism is characterised by low and highly variable rainfall conditions, steep terrain, or extreme temperatures (Megersa et al 2014). Pastoralists inhabit zones with the potential for crop production. The livelihoods of pastoralists depend on their knowledge of the surrounding ecosystem and on the well-being of their livestock (Tefera, & Shewadeg 2022; Truebswasser & Flintan 2018). Africa contains one half of the world's pastorals; thirteen million Africans are predominately pastoral and another nine million are agro pastoral, keeping large numbers of livestock while practising agriculture (Lumborg, Tefera, & Munslow 2021). Pastoralists move from place to place in search for grazing land and water for their livestock (Lumborg et al 2021; Abdullah 2005:7). Mobility is a key feature of pastoralism. Their economic and social system was adapted to dry land conditions and is characterised by a complex set of practices and knowledge that has permitted the maintenance of a sustainable equilibrium among pastures, livestock, and people (Megersa et al 2014). However, pastoral communities are marginalised and generally not given due consideration in the wider development spheres. These communities are vulnerable to climate change, shifting global markets, population growth and increased competition for land and other natural resources. People living in the remotest arid land areas do not have enough access to basic services such as health, education, legal, electricity, and developmental infrastructures (Megersa et al 2014; Calvasa et al 2009:2). In such marginalised culturally bound social groups, addressing basic HIV/AIDS information, education, and communication requires careful message design. To properly communicate HIV/AIDS messages in pastoral Africa, including Ethiopia, there is a need to tailor the messages to the local context (UN OCHA-Ethiopia 2004). The following topic highlights the situations surrounding the HIV/AIDS epidemic under East African pastoralists.

2.4.1 Pastoralism and HIV/AIDS in East Africa

The livelihood of pastoralists in East Africa and in the Horn of Africa depends on livestock (Carrington 2019; Catley 2017).

It involves movement from one location to another, based on the seasonal availability of pasture and water (Lumborg et al 2021; Catley, Lind& Scoones 2013). East Africa, Djibouti, Eritrea, Ethiopia, Kenya, Somalia, South Sudan, Sudan, and Uganda have the largest proportions of cross-border mobile pastoralists and refugees (Serbessa et al 2016). Individual herds of cattle are privately owned, while land is held communally and livestock movements are planned by consensus among community elders, based on the prevailing seasonal climatic conditions (Lumborg et al 2021).

The pastoralist community in East Africa remain socially and economically marginalised and have little representation in local and national government (Catley 2017). Most governments in the region consider pastoralism as unsustainable and a barrier to development (Catley 2017). Pastoralists are the most politically marginalised group in the Horn of Africa and East Africa (Carrington 2019; Oxfam 2008). These groups of people find themselves politically disempowered and economically marginalised. The IGAD Regional HIV & AIDS Partnership Programme (IRAPP) was established in 2007 to mitigate the challenges of HIV among neglected pastoral communities (Serbessa et al 2016). However, pastoralists remain susceptible to different problems, including health problems (Catley 2017; Herrero et al 2016). Poor socio-economic status, harmful traditional practices and a limited health infrastructure contribute to the continuing HIV risks among the community. HIV/AIDS intervention among the pastoralist community of East Africa requires the provision of appropriate health services and understanding the contexts within the community. There is a need to integrate HIV/AIDS programmes to the contextual domains of the impoverished pastoral community (Serbessa et al 2016; Herrero et al 2016).

Livestock production is a base for a considerable number of populations in East Africa. It is one of the predominant livelihoods of this region (Kinaroet al 2018). It contributes significantly to the national economy and can preserve the delicate natural resources. However, pastoralists' representation in different development activities remains low in East Africa. There is the misunderstanding that pastoralism is unsustainable and a barrier to development (Kinaro et al 2018). Services like gender inclusion in education remain low in the pastoralist regions of East Africa. Though governments may have taken steps to address the gender gap in education, these measures are not reaching pastoralist girls and women.
The pastoralists' culture excludes women from important roles; women are expected to respect and submit to the leadership of men. Women in the pastoralist regions of East Africa continue to be subjected to gender-based violence such as early forced marriage and the

related gender-based abuses like harassment and gender-based discrimination (Kinaroet al 2018).

The pastoralist community in Africa, including the Borana pastoral community, has been facing problems relating to the environment, socio-economic, political, and cultural aspects. The government policy in Africa lacks adequate consideration for pastoral developments. The pastoral community was not given due emphasis in the multifaceted development activities like health. Pastoral regions in East Africa require essential consideration in the development policies (Kinaro et al 2018).

2.4.1.1 Pastoralism and HIV/AIDS in Ethiopia

Ethiopia is a predominantly rural country. In 2015, the rural population was estimated to be approximately 80.5 million, or 81% of the total population (UNDESA 2018; CSA 2013). According to the World Bank report (February 2024), rural population in Ethiopia was reported at 77.34 %. Pastoralists in Ethiopia reside in the remotes low land of rural areas. Pastoralists in Ethiopia are mainly found in four lowland regions, Afar, Somali, Oromia, and the Southern Nations, Nationalities and People's (SNNP) regional states. Pastoral groups are also found in Gambella and Benishangul areas. The main livelihoods systems include pastoralism, farming and ex-pastoralism – those who have dropped out of pastoralism and now survive on petty income-earning activities (Behnke et al 2007).

Ethiopia has Africa's largest livestock population. This livestock population is concentrated in the pastoral areas of the country. Reports show that Ethiopia has an estimated 41 million cattle, 26 million goats, and two million camels (Elias 2016; Abdulahi 2005). In Ethiopia, "pastoralists are the minorities made up of 29 different ethnic groups belonging to Cushitic and Nilo-Saharan language families and are estimated to represent 12% of the population occupying more than 61% of the total territory. Most pastoralists in Ethiopia belong to the Somali, Borana Oromo (the area of this study) and Afar groups. They live in the peripheries of the country, bordering neighbouring countries" (Abdulahi 2005:8-9).

In Ethiopia, pastoralists and agro pastoralists are found in the lowlands, which are commonly arid or semi-arid and sparsely populated (FAO 2018). It covers 61% of Ethiopia's total land mass, with 97% of pastoralists concentrated in the northeast, east, and south. Somalia has the highest number of pastoralists (53%), followed by Afar (29%), Borana (9%), and the other 8% are found in the Gambella, Benishangul, and Tigray regions of Ethiopia (USAID 2016). It provides livelihoods to more than 12 million Ethiopians, who derive most of their income from keeping livestock and complement it with farming in the case of agro

pastoralists (CSA 2013; FAO 2018). Economically, the sector contributes 20% to Ethiopia's Gross Domestic Product (GDP) through the livestock subsector (Abduletif 2019; Ayele, Dedecha& Duba 2020). Ethiopia, like many low-income countries, is disproportionally vulnerable to the adverse effects of climate change (Lumborg et al 2021). People residing in the arid areas did not get adequate attention in the development projects. Social service outreach, such as health services, and public health research among pastoralists in the lowland areas are minimal (Waters-Bayer, Birmeji & Mengistu 2005:1).

Pastoralists constitute a large portion of the Ethiopian population, representing an estimated 14–18% of the population (Yitbarek et al 2022). Literacy plays a significant role in improving societal health (Warkineh& Gizaw 2019). Considering educational coverage, little attention has been paid to the development of the pastoralist community in Ethiopia (Tofu et al 2023). Pastoralists are a neglected group who lack access to basic services like health education (Lumborg et al 2021).Given the region's poor development policies, basic social services like health, education, electricity, roads, communications, access to agricultural extension services, access to credit, and insurance services are typically lower than in other regions (UN 2010).As a result of this, illiteracy is quite high as most children drop out of school (UNICEF 2014). The policymakers often overlook development activities in the pastoral areas, focusing on the interests of agricultural and urban dwellers (Mohamed2019).

According to the study by Serbessa et al (2016), Intergovernmental Authority for Development (IGAD) member states (Djibouti, Eritrea, Ethiopia, Kenya, Somalia, South Sudan, Sudan and Uganda) have the largest proportions of cross-border mobile pastoralists and refugees in Africa. The study shows that although all IGAD countries have had national HIV/AIDS prevention, care and treatment programmes since the late 1980s, the IGAD Regional HIV & AIDS Partnership Program was (IRAPP) established in 2007 to mitigate the challenges of HIV among neglected pastoral and refugee communities (Serbessa et al 2016). Most HIV/AIDS related studies focusing of pastoral communities in IGAD countries were found to be limited in scope and coverage but reveal precarious situations. Sero-prevalence among various pastoral populations ranged from 1% to 21% in Ethiopia, Kenya, Somalia and Uganda and from 1% to 5% among refugees in Sudan, Kenya and Uganda. Socioeconomic, cultural, logistic, infrastructure and programmatic factors were found to contribute to continuing vulnerability to HIV (Serbessa et al 2016).

HIV/AIDS interventions among the pastoralist areas of IGAD countries including of Ethiopia overlooked the local contexts.

In this regards the study by Serbessa et al (2016) indicated that HIV/AIADS Interventions in the pastoral community of IGAD countries need to be further contextualised to the needs of those impoverished populations and integrated into national HIV/AIDS programmes. HIV/AIDS remains a major public health concern among the pastoral and refugee communities of IGAD countries.

Health literacy (the ability to obtain, process, and understand basic health information to effectively navigate the health system) is mainly identified as an individual trait (Lindgren et al 2018). It has become an important component in the management of complex and chronic diseases such as the HIV infection (Mgbako, Conard &Mellins 2022). There is a significantly high illiteracy rate in the pastoral community of Ethiopia. Health literacy is a key factor in the health of the individuals and the treatment of HIV/AIDS. It improves medical interventions and outcomes (Tasah 2021). Illiteracy therefore highly contributes to negative health outcomes among the pastoral populations (UN OCHA-Ethiopia 2004). HIV/AIDS communication among the pastoralist populations should consider the literacy rate (Tasah 2021). This is because pastoralists have less exposure to health IEC. However, HIV/AIDS IEC have not been tailored to the livelihoods of the pastoral community. Health services in the pastoralist communities are not in line with the socio-cultural contexts of the specific pastoral community. This indicates that HIV/AIDS campaign programmes lack context and consideration.

In pastoral areas in Ethiopia, there is a lack of development policy focusing on human capital development programmes (Gebremeskel, Desta, & Kassa 2019). The pastoralist community in Borana seek pragmatic policies that are consistent with Indigenous knowledge contexts (Rettberg et al 2017). This is because the existing sexual and reproductive health (SRH) services in pastoralist areas are currently not well suited to meet the needs of pastoralists (Zepro et al 2023). This can be applied to the Borana pastoralists where there are limited health services. In addition, the inability to contextualise HIV/AIDS communication to the pastoralists' realities could make the community susceptible to the rapid spread of HIV/AIDS (Waters-Bayer, Birmeji & Mengistu 2005:2). The rate of HIV infection is rising slowly in the rural areas of the pastoral populations (UN OCHA-Ethiopia 2004).

There is evidence suggesting that socio-cultural contexts in pastoral settings play an important role in the use of SRH services (Zepro et al 2023). This is because pastoral settings often have certain cultural practices, beliefs, and norms that can influence perceptions of health and illness, as well as their willingness to make use of health services.

However, little is known about the effectiveness of interventions aimed at improving SRH services in pastoral settings (Zepro et al 2023). The evidence on the relationship between socio-cultural contexts and the use of health services in pastoral settings is scarce (Kinaro et al 2018). This is likely due to the diversity of pastoral communities and the lack of research on this topic (Gammino et al 2020).

Pastoral communities in Ethiopia need to have strategic HIV/AIDS communication, which caters for the specific contexts of their communities. HIV/AIDS communication approaches should use the positive local cultural resources in the pastoral community that would promote a positive behavioural change towards HIV/AIDS. The communication approaches should be pastoralist friendly. To promote HIV/AIDS campaigns in the pastoral areas, a need exists to be more inclined towards strategic communication (Waters-Bayer, Birmeji& Mengistu 2005:4). The subsequent topic discusses the HIV/AIDS situation at the study site.

2.5 BORANA PASTORALISTS AND THE HIV/AIDS SITUATION

Geographically, Borana is one of the administrative zones in the Oromia regional state. The Borana zone is situated in a relatively arid area of the southern part of Ethiopia. It borders with Somalia to the east and Kenya to the south. The most recent census estimates the Borana population at a little over one million (Serbessa 2019). The zone is divided into 13 administrative districts. Livestock rearing is the major economic basis for Borana. Borana people in all districts share common socio-cultural features (Serbessa 2019).

The Borana pastoral community has maintained the traditional Oromo institutions like *Gadaa*. “The *Gadaa* system is an institution at the core of Oromo socio-politics, serving political, judicial, and ritual functions among the Borana people” (Andrew et al 2007). The leader of *Gadaa* is known as *Abbaa Gadaa* (father of *Gadaa*) who is elected every eight years. The Borana Oromo people are loyal to the traditional leader, *Abbaa Gadaa*. Issues central to the Borana is discussed among multiple people in the highest Borana assembly of the *Gadaa* organ, called *Gumii Gaayyoo*. At this assembly, people get the chance to debate and participate in a consensus-based decision-making process. When it comes to religion, the Borana are affiliated with the traditional Oromo belief in the existence of a supernatural power which they call, *Waaqa*. Although the majority of Borana Oromo follows the Indigenous religion, *Waaqa*, there are also Islam and Christian religion followers in Borana.

The Borana pastoralists consider land and pasture as the communal property of all the members of their group (Abdulahi 2005:9). Pasture is considered a gift from "*Waaqa*" (God) and it does not belong to any specific individual. Access to rivers and rainwater is free to all, including neighbours. This is typical of pastoral communities throughout south-eastern Ethiopia, where rights to access natural water reserves depend primarily on its availability. Among the Borana clan, identity is important for gaining access to resources. The Borana cultural institutions are helpful in regulating access and use of the natural resources (Watson 2014:8). This shows that the Borana people are primarily led by the established cultural norms and *Gadaa* systems of governance.

HIV and AIDS tend to be related to risk and vulnerability in the pastoral community. While risk is an outcome of threats/hazards/stressors, vulnerability is the potential to be exposed to but lack of means to cope with threats/hazards/stressors (WHO 2011; Nirupama 2008).In Ethiopia, generally there is limited studies on vulnerability particularly in connection to the epidemic of HIV (Serbessa 2019). However, there are reports from epidemiological synthesis that documented market places, urban settings, and prisons as hotspots (Serbessa 2019). The same report and some others have further documented that female sex workers, mobile workers, in and out of school youth, uniformed services, widows, divorcees and separated women are most at risk (Berhane et al 2018). Furthermore, concurrent extramarital sexual practices, polygamy and marrying a sister of a deceased wife are documented as facilitators of HIV infection (Kaba et al 2016). Although it is not well documented, the tradition of keeping an extramarital sexual partner by men as well as women, widow inheritance and polygamy appears to have declined although they are still there in secret Mirgissa et al 2013). Despite lack of studies on vulnerability to among the Borana population, a few behavioural and biological studies show relatively high HIV prevalence in the region as compared to similar settings (Tefera and Ahmed 2013; Mela Research2014).

Unprotected sexual practices remain a challenge among the Borana pastoral community. As a result, the community has become vulnerable to HIV infections connected to their risky sexual practices (Serbessa et al 2016:7). HIV/AIDS prevention in Borana focused on approaches of expert-based IEC. For instance, HIV/AIDS prevention mechanisms like abstinence, condom use, and faithfulness have long been the centre of the campaigns in the pastoralist community (Serbessa et al 2016). However, the proposed HIV/AIDS prevention approaches that don't consider the socio-cultural contexts of the pastoral community were not successful in bringing along social behavioural change.

There is a need for designing interventions that are informed by the local contexts (Serbessa et al 2016). The local cultural resources in Borana were not adequately used to prevent the spread of HIV/AIDS (Serbessa et al 2016). The communication approaches should coincide with the life realities of the target audience (Serbessa et al 2016; Dugassa 2014; Aguilar 2009). The next section discusses gender roles in relation to HIV/AIDS among the Borana pastoral community.

2.5.1 Gender mainstreaming and HIV/AIDS among Borana pastoralists

Gender mainstreaming is defined the process of assessing the implications for women and men of any planned action, including legislation, policies or programs, in any areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programs in all political, economic, and societal spheres so that women and men benefit equally and inequality is not perpetuated (Mehra & Gupta 2006).

Gender roles are based on the different expectations that individuals, groups, and societies have of individuals based on their sex and based on each society's values and beliefs about gender (Tesha et al 2023; Garrison-Desany et al 2021). Shifts in pastoral livelihoods destabilise well-defined boundaries of gender roles and age among traditional communities based on the principles of patriarchy (Bryceson 2019; Wangui 2008). Pastoral women are at the very centre of this inequitable paradox. They shoulder a significant portion of the household burden in responding to climate change (Anbacha & Kjosavik 2019b) and simultaneously face multiple gendered barriers, such as lack of access to credit, land tenure rights, and gender-based violence (Anbacha & Kjosavik 2019a).

Understanding how pastoral households respond to drought and the gendered impact of these responses is critical to identify potential strategies and interventions aimed at supporting the climate resilience of pastoral women and their communities. Extramarital affairs have a gender dimension in which women can be more exposed to extramarital affairs and HIV infection based on various gender dynamics including women's economic hardship, social beliefs, and the masculinity norms (Mtenga et al 2018). Extramarital concurrent sexual practise is widespread and tolerable among the Borana (Kaba, Ame & Mariam 2013:26).

In Borana, roles are structured based on gender and age groups, with women responsible for activities in and around their dwellings, whereas men are responsible for livestock management (Anbacha & Kjosavik 2019). Women and men have common and separate responsibilities within a Borana culture. The division of women and men's labour, as well as roles at community level, are flexible. For example, while women take full responsibility for managing small animals, dairy production, fetching water (which can take up to nine hours per day) and gathering fuel wood, men will occasionally assist women particularly with fuel wood collection (Anbacha & Kjosavik 2019). Women share other tasks with men such as working on the farmland and making charcoal. Women sometimes take the cattle to the water points (traditionally a man's role). In Borana, women bear a disproportionate burden caused by environmental problems like drought, because of their traditional roles and structural inequality in accessing basic resources (Anbacha, & Kjosavik 2021:9). Anbacha and Kjosavik (2019) have highlighted pastoral women's trouble due to climate-related stressors that expose them to different problems, including health. The following table summarises gender roles among the Borana population:

Women	**Men**	**Both**
• transporting harvest • planting • building pens • collecting grass & fodder • milking cows • making butter • fetching water • gathering/selling fuel wood • basket & mat making	• land preparation • cultivating • selling of cattle	• taking cattle to graze • weeding • harvesting • making charcoal

Table 2.1: Labour divisions in Borana
Source: Anbacha Kjosavik 2019

As Table 2.1 above indicates, gender-based inequality is still deeply rooted in both urban and rural parts of the country. The problem is more pronounced in rural pastoralist areas, such as the Borana, where women are subjected to different forms of exclusions and became the primary victims of the negative effects of climate change and other socio-economic dynamics that affect their livelihood system (UN OCHA 2017).

In addition to the responsibilities in livestock production and the gender division of labour puts a heavy burden on pastoral women as they are almost entirely responsible for all domestic activities including fetching water, firewood collection, cooking, taking care of children, the sick and the elderly (Chala & Haro 2023). Traditional institutions, including the *Gadaa* system, are male dominated and adversely affects women's role in their respective communities (UN OCHA 2017). There is a traditional dominance of men over women in almost all aspects, including property ownership, control and decision-making over economic resources, and control of political decision-making institutions (UN OCHA 2017).

In Borana, boys tend to get priority although this is currently changing. Household property is under the husband's control (Tofuet al 2023). In Borana, descent is accepted through the male line. Women are culturally considered subordinate to the men. Women in the pastoral population have fewer mandates to decide on their rights (Tofuet al 2023). Furthermore, Borana's women participating in decision making at household level is limited to the areas socially assigned to them. Cultural expectations of masculinity encourage men to assume the patriarchal attitude that wives, partners, and daughters are the possessions of men, and most husbands expect (or demand) their conjugal right (Ramjee & Daniels 2013). In such a case, a woman is considered her husband's property. "Bride payments" is when the bride's family receives financial compensation from the potential husband (Ramjee & Daniels 2013). In a gender-discriminating cultural group like the Borana, this implies that women are not empowered to make decision on issues that affect their lives.

In Borana Gadaa system, male dominated and adversely affects women's role in their respective communities. Men lead and participate in the Gada culture of governance. Gada culture of democracy is also criticized because of less attention given to females to take the leadership role like men (Legesses 1973). This implies the place of women in the Borana cultural system of governance (*Gadaa*) is insignificant compared to their male partners. Boys have more opportunity to attend schools compared to girls. Girls' education is culturally less supported. It is important to note that Borana women have less opportunity and power to exercise their own rights, including health rights. In such a male-dominated social structure, it is difficult for women to decide on these resources including their own sexual interest. Women are supposed to serve the interest of their male partners. This gender influence in the pastoral population paves a way for the rapid spread of HIV/AIDS. Therefore, HIV/AIDS communications should consider the gender issue as a major contextual domain to tackle

HIV/AIDS problems in pastoralist communities like Borana (Mtenga et al 2018; Ramjee & Daniels 2013). The next section discusses HIV/AIDS vulnerability in the context of this study.

2.6 VULNERABILITY, MOBILITY, AND STIGMA IN RELATION TO HIV/AIDS

In the past, HIV/AIDS communication was focused on interventions targeting at-risk groups, such as commercial sex workers, long-distance drivers, and migrant populations (Lumborg et al 2021). Pastoralists were not considered among the key population or risk groups that may be exposed to the problems of HIV/AIDS. This means that pastoralists were not given attention in the HIV/AIDS prevention strategies. In addition, HIV/AIDS interventions in the past focused on the medical aspects which overlooked the socio-cultural contexts that may fuel the spread of the epidemic. The concept of at-risk groups has been extended to risky behaviour such as unprotected sexual intercourse. Most HIV prevention programmes first concentrated on reducing the immediate risk of HIV infection by bringing about change in sexual behaviour. The risk approach did not consider the fact that behaviour is often not rationally determined. Moreover, people cannot implement what they have recognised as correct if they do not have the means to make self-determined decisions (Zepro et al 2023). Marginalised population groups at the peripheries that have no adequate access to HIV/AIDS information, education, and communication have been affected by different health hazards such as HIV/AIDS. The pastoralist community in Borana have less access to health information and services (Serbessa et al 2016). The Borana pastoral community encounter the risk of HIV/AIDS due to traditional practices such as extramarital sexual intercourse, widow inheritance, polygamy, and early marriage. In addition, the community moves from place to place in search of grazing land and pasture for their cows. Challenges due to HIV/AIDS increase with vulnerability to the epidemic (Ssebunya et al 2019). Vulnerability to HIV infection is due to limited self-determination in social, sexual, and other areas concerning HIV/AIDS. It also relates to the higher susceptibility of these groups to the negative social effects of the epidemic. Underprivileged population groups are therefore highly exposed to HIV/AIDS risks (UNAIDS 2010).

As discussed in the introduction (section 1.2.1), rural communities in Ethiopia are among the underprivileged and marginalised groups who do not have enough access to health services. There is also gender inequality in the context of Ethiopian populations, such as the pastoralist community. The limited health services in this pastoral population require a tailored approach to the contextual domains of the target population.

As a result, there is high demand to assess the cultural appropriateness of HIV/AIDS communication among the pastoralist community in Borana, Ethiopia.

Mobile population groups and migrants are among sections of the society that are highly susceptible to the risks of the HIV/AIDS epidemic (Thorp et al 2023; Edwards et al 2019; Larmarange et al 2018). Migrants and mobile populations have an increased risk of HIV infections (Ssebunya et al 2019). People who move from place to place for the sake of survival may face HIV/AIDS risks due to different socio-economic factors. In Ethiopia, there are also population groups who move from place to place for varied reasons. The Borana pastoralist community, the subject of this study, move from place to place in search of pasture and water for their cattle. This population group lead a customary way of life. They have less exposure to modern education and information about HIV/AIDS. There are traditional cultural practices that the pastoral community have been practising for very long. The HIV/AIDS message is supposed to fit in to the day-to-day life of the pastoralist groups who have strong cultural bonds and traditions. Besides in developing countries, where there is gender inequality, mobile pastoralist women are highly exposed to the risks of HIV/AIDS. There are cultural practices that affect the health of women (Mtenga et al 2018; Ramjee & Daniels 2013; Shira et al 2012). It is vital to study the appropriateness of HIV/AIDS communication in the lives of the pastoral community in Borana, Ethiopia. Moreover, HIV/AIDS risks can affect different life contexts, such as the social and economic context of a population.

Stigma concerning to HIVAIDS occurs across all socio-ecological levels such as structural, communal, organisational, interpersonal, and individual (Stangl et al 2019). The processes and manifestations of stigma are influenced by the social (e.g., cultural and gender norms) and structural (e.g., policies and laws) factors in any given context (Stangl et al 2019). For example, social-cultural norms across many sub-Saharan African contexts facilitate an adolescent sexual and reproductive health stigma related to sexual activity outside of marriage, unintended pregnancy, and contraception that influence the acceptance and delivery of sexual and reproductive health services, particularly in association with HIV/AIDS (Robert et al 2020; Logie et al 2019). HIV/AIDS is highly associated with stigma and discrimination which creates a fundamental obstacle in the fight against HIV/AIDS (Embleton, Logie, & Ngure 2023; UNAIDS 2013). The stigmatisation and taboo label of HIV/AIDS also cause people to shun the subject and repress it. Silence frequently blankets the themes of sexuality and death, which are intimately related to HIV (Sonja & Christoph 2004:46-47).

Stigma and segregation due to HIV/AIDS hinders the effort to tackle the changes due to the epidemic (FHAPCO 2007). To overcome the problems of stigma AIDS communication should not convey negative messages about sexuality.

In the Borana pastoralist community where sexual topics are taboo, it is imperative to understand that sexuality is a gift, and people should be responsible while having sexual intercourse (Sonja and Christoph 2004). “Women living with HIV/AIDS believe they are more stigmatised because they are held to a higher sexual standard than men and are judged more harshly for contracting HIV/AIDS” (Lekas, Siegel, & Schrimshaw 2006:65). In the Borana pastoral community, sexuality is a taboo topic. To ban the cultural traits that hinder effective HIV/AIDS communication, the communication needs to be reframed. Religious people, opinion leaders, and health professionals should work together to manage the HIV/AIDS problem due to these stigmas. Positive cultural and religious beliefs as well as practices that would pave the way to prevent the HIV/AIDS epidemic should be incorporated (Mapingure, Mukandavire & Chingombe 2021; Mtenga et al 2018). The next section highlights the disadvantaged population and HIV/AIDS risks.

2.7 HIV/AIDS RISKS AND THE DISADVANTAGED POPULATION

HIV/AIDS negates the socio-economic advances of the developing countries (WHO 2022). Poor population groups are vulnerable to the risks of HIV/AIDS (Sonja & Christoph 2004:40-45). The impact of the HIV/AIDS epidemic is serious (Peinado et al 2020). Loss of experienced and skilled workers may lead to low productivity. People living in poverty are even further impoverished by HIV/AIDS. In addition to the socio-economic problem, in a country where there is gender inequality, the effort to control HIV/AIDS would be more challenging (Monod et al 2023; WHO2010). Insidious socio-economic problems and gender inequality lead people to problems like migration and commercial sex work that has its own implication on the spread of HIV/AIDS. This would make people susceptible to the risks of HIV/AIDS. Ethiopia is one of the poorest countries in Africa. Challenges due to HIV/AIDS threaten the life of its people. Rural Ethiopia is an especially disadvantaged part of the country when it comes to accessing contextualised HIV/AIDS IEC. It’s imperative that HIV/AIDS communication consider the socio-economic status of the target audiences.

HIV/AIDS is not only about health risks, it is also linked to the socio-economic and political crises.

The problems of HIV/AIDS have a severe impact on the socio-economic, as well as political, developments of a community. In a culturally bound society like the Borana pastoral community, HIV/AIDS communication strategies should consider the geographical and demographical contexts of the target community for effective message delivery (Rogers et al 2021; Edwards & Barker 2014). There should be an understanding among the stakeholders that the danger of HIV/AIDS is not limited to the health risks of the pastoralist community. It also has the power to impede the socio-economic and political developments of the target pastoralist people. The next topic presents the HIV/AIDS prevention programme and the importance of understanding contextual factors.

2.8 HIV/AIDS PREVENTION PROGRAMME: CONSIDERATION OF CONTEXTUAL FACTORS

HIV/AIDS programmes must consider the contextual factors such as the socio-cultural context of developing countries (UNAIDS 2018). HIV/AIDS prevention and care programmes however, has not yet addressed the realities of the marginalised community (UNAIDS 2018). HIV/AIDS policies and programmes of the developing countries should consider the contextual factors in the local areas. In Ethiopia, the national HIV/AIDS policy did not address key socio-cultural factors that drive the spread of HIV/AIDS (FHAPCO 2007). Moreover, there was limited evidence available on the socio-cultural factors fuelling the spread of HIV/AIDS in the underprivileged populations of the developing countries, like the rural community in Ethiopia. “Identifying factors which fuel the spread of HIV/AIDS in the rural areas not only serves to strengthen effective responses against the epidemic, but also indicates where to invest scarce resources efficiently” (Khandu, Tobgay & McFarland2020; FHAPCO 2007). In Ethiopia, HIV/AIDS messaging was not sufficiently adjusted to the existing local contexts. HIV/AIDS prevention and care focused on the epidemiological aspects. Diverse types of harmful traditional practices exist in the country, and yet, their contribution to the spread of the HIV infection was largely unknown (Khandu, Tobgay & McFarland 2021; Okechi 2018; FHAPCO 2007). The campaigns against HIV/AIDS among the pastoral community are possible with consideration of the contexts of the target community.

These contexts include “the socio-cultural (race, class, gender, and culture), the interpersonal (support and stigma), the temporal (historical time or developmental stage in an individual’s life), and the situational (contexts specific to a person’s experience such as

pregnancy)" (Klonoff 2009:49).HIV/AIDS prevention programmes in Ethiopia should therefore consider socio-cultural issues and contexts like culture, gender, religious/spiritual practices, social behaviours, and conditions that protect people or make them more vulnerable to insufficient resources. For effective HIV prevention in Ethiopia, HIV/AIDS programmes need to consider the socio-cultural factors in communicating HIV/AIDS messages.

Contextual factors such as culture not only influence the experience of living with HIV/AIDS, it affects how individuals incorporate the HIV/AIDS identity into the self (Baumgartner 2012:2). Identity theorists further maintain that identity is part of the context that needs consideration in HIV/AIDS communication. People possess multiple identities that form a stable self. An individual's identity is formed through interactions with others and remains established. Self-identity, group identify, as well as the relationship identity between and among cultural groups should be considered for effective HIV/AIDS communication. People construct different self-identities such as an identity for sex, language, class, nationality, culture, religion, and gender. HIV/AIDS messages should be incorporated into one's self-identity (Baumgartner & David 2009). To date, HIV/AIDS identity incorporation focused mainly on the impact of the interpersonal context on the process (Baumgartner 2012; Baumgartner & David 2009). The impact of the socio-cultural context on the incorporation of the HIV/AIDS identity into the self-did not get much attention (Baumgartner 2012:3). Context could provide a stronger impact on HIV/AIDS care and prevention (Kinaro et al 2018). Social class divides everybody: high-tech or low-tech culture, rich or poor, high, low, or middleclass, educated or non-educated. The way someone constructs meaning for his/her class affects how they understand and accept health messages (Kinaro et al 2018). Self-knowledge, attitude, belief, social acceptance, and image, affect how people understand and accept health messages (Kinaro et al 2018). The influence of class on personal identity is of interest since it is an individual's positionality and personality that intermingles with another individual's positionality and personality (Baumgartner 2012:3). Considering the local realities, like the culturally taboo nature of sexual topics, is crucial for effective communication.

In general, socio-cultural contexts which include the totality of people's social experiences such as culture, language, norms, value systems, religion, and spirituality (multiple identities) affect the health behaviour of a community. In line with this, Airhihenbuwa (2007) argues that HIV/AIDS communication in Africa overlooked the socio-cultural contexts of the native community.

The socio-cultural context affects the experience of living with HIV/AIDS; a more thorough investigation of the connection between the socio-cultural contexts and HIV/AIDS campaigns for a specific cultural group needs further investigation (Paige 2019; Sovran 2013; Airhihenbuwa 2007; Airhihenbuwa & Webster 2004). Chapter 3, Part II (health models and theories) and Chapter 4 (conceptual framework) discuss the fact that HIV/AIDS communication in Borana should consider the traditions that contribute to the spread of the epidemic. The socio-cultural approach to HIV/AIDS prevention helps to design culturally suitable messages that help to effectively curb the spread of the epidemic (Iwelunmor, Newsome &Airhihenbuwa 2014; Airhihenbuwa 2007a; Zimmerman, Christakis & Meltzoff 2007). HIV/AIDS prevention programmes among the pastoralist community failed to bring the intended social behavioural change due to the contextual factors. In addition, HIV/AIDS communication and prevention programmes are not well contextualised to the specific contexts of the target community.

2.9 CONCLUSION

Chapter 2 started with the literature review. The chapter empirically discussed the global expansion of HIV/AIDS and its effects in Africa, specifically on the Borana pastoralists in Ethiopia. HIV/AIDS issues were discussed in socio-cultural contexts. The chapter also focused on HIV/AIDS communication in developing countries where the target community's socio-cultural contexts are ignored. The focus of this study is on HIV/AIDS from a global perspective with specific focus on the Borana pastoralists in Ethiopia. Additionally, the HIV/AIDS programmes of poor countries are not culturally tailored. Therefore, HIV/AIDS threatens sub-Saharan African nations like Ethiopia (Abamecha et al 2021; Serbessa et al 2016; Mamo et al 2019). Sex workers, migratory populations, migrants, women, and long-distance truck drivers are particularly vulnerable to HIV/AIDS. Harmful practices, gender inequality, low literacy, resource scarcity, and poor communication make these populations prone to HI/AIDS. Borana pastoralists are noted for their extramarital sexual activity, widow inheritance, polygamy, and HIV/AIDS-promoting beliefs. The health initiatives are not customised to the population's socio-cultural situations. In addition, socio-cultural factors impacting the HIV/AIDS prevention in Borana, Ethiopia are poorly documented. Since pastoral communities are concerned about HIV/AIDS, this research gap needs to be addressed. Borana pastoralists in the lowlands lack contextualised HIV/AIDS education, information, and communication (Abamecha et al 2021; Serbessa et al 2016; Mamo et al 2019). The current viewpoint is that HIV/AIDS communication and programmes should match the target population's socio-cultural circumstances. In Chapter 3, Part I, health communication is discussed in relation to the context of this study.

CHAPTER 3 (PART I)
HEALTH COMMUNICATION, HEALTH PROMOTION, AND UNDERSTANDING SOCIO-CULTURAL ASPECTS OF HEALTH COMMUNICATION

3.1 INTRODUCTION

This chapter deals with the scholarly literature pertaining to health communication, health campaign strategies, new intervention to health communication, the rational to integrate health communication to the socio-cultural contexts, and health decisions nexus to human rights. The current observation in developing countries indicates that health communication is not adequately contextualised in line with the target audiences. This means that the design of health messages and the communication approaches were not effectively integrated with the local contexts of the target community in Africa. Health communication should consider the social and cultural values, norms, and traditions as these contexts influence individual lifestyles and behaviours of the population affected by HIV/AIDS (Khandu, Tobgay & McFarland2021) Health communications were not conceptualised systematically to the contexts of the target population in Africa (Douglas et al 2014:12). Health messages reception is only effective when it suits the contextual domains (Usonwu, Ahmad, & Curtis-Tyler 2021; Van Servellen 2009:23). In addition, health messages in the context of the developing nations seemed targeted to a more general audience. Messages have not given adequate attention to the differences in the community such as culture, religion, social values and norms, language, gender, belief systems, and the day-to-day life experiences of a culturally bound community like the Borana pastoralists. The problem with health messages is not a lack of information in health, but that it is uncoordinated with the population's life style. A change in thinking and practices are necessary in disease prevention, care, and treatment. The shift is from medical epidemiology to integrated socio-medical epidemiology. Understanding the socio-cultural aspects of a community has become vital for effective health message delivery.

3.2 HEALTH COMMUNICATION

Health communication is a multifaceted field that encompasses diverse approaches such as the socio-cultural aspects and processes through which information is exchanged between healthcare providers and beneficiaries (Vermund et al 2017; Vermund, Van Lith & Holtgrave 2014:1).

The health messages, medium of communication, and style of the messaging should suit the different socio-cultural contexts of the target community (Vermund, Van Lith & Holtgrave 2014:2). Audiences differ in their assumptions, attitudes, self-efficacy, and receptivity to messages. Hence, health communication among the pastoralist community of Borana should consider the local audience's realities for message effectiveness. This is because health messages can be influenced by language, culture, religion, gender, age group, experience with the health topic in question, level of trust, degree of social isolation or integration, social norms, and other elements in a person's background (Vermund, Van Lith & Holtgrave 2014:2). HIV/AIDS messages should respond to the socio-cultural factors that shape peoples' behaviour. The communication strategies should influence decisions that enhance positive health behaviour. Communication in health plays a key role in the health message transactional processes (WHO 2009). Communication can take place in different situations such as politics and economics. Health communication is seen as a "resource" that allows health messages to be used in the avoidance of ill health. Health communication, an approach within the social and behavioural sciences, is therefore communication that intends to ensure social health. The integration of health communication and other social behavioural interventions is vital to tackle health hazards including HIV problems. Social and behavioural interventions in health can play a crucial role (Gardner et al 2011:793). It is essential to inform and influence decisions that enhance societal health behaviour (Tomori et al 2014:2).

In the past, health communication was viewed as one-way communication used to change individual behaviour (Bose et al 2023). However, one-way communication is proved ineffective to bring about the intended behavioural change (Bose et al 2023). Social behavioural change is essential in a collectivist culture like the Borana pastoralists. As a result, there are shifts in the current health communication. The shifts are from one-way communication to multi-level communication, individual behavioural change to social behavioural change, epidemiological focus to integrated social epidemiology, and western-dominated health models and theories of communication to integrated contextual domains (see Chapter 2). Health communication is an integral part of interventions that seeks to address individual, community, social, and political factors. Communication can have a significant impact on multiple levels of implementation in each step of the healthcare process.

Health beliefs are not universal (Wanyoike 2011:80). Health belief are what people believe about their health, what they think constitutes their health, what they consider to be the

cause of their illness, and ways to overcome an illness (Misra & Kaster 2012). Health beliefs are culturally determined, and all come together to form larger health belief systems (Misra & Kaster 2012). Communication should consider the health beliefs of the target population. Health professionals must be sensitive to different culturally based health beliefs, values, and attitudes that influence the interpretation of healthcare (Page 2019:23). Health perception is a crucial aspect of health communication. As a result, health communication should consider the health perception of the target community. HIV/AIDS communication among the Borana pastoral community should identify the health belief and perceptions of the target population. The community level HIV/AIDS communication should be integrated with the lived experiences of the community. Health professionals have the ethical and moral responsibility to consider the context of the target community. Therefore, HIV/AIDS communication among the Borana pastoralists need to consider the realities of the local community to render appropriate services. The need to understand health communication is explained in the next section.

3.3 UNDERSTANDING HEALTH COMMUNICATION: TAILORING HEALTH MESSAGES TO THE SOCIO-CULTURAL CONTEXT

Communication science seeks to understand diverse processes and effects, including how different channels and types of information can be mobilised instrumentally and strategically in domains such as public health (Storey et al 2014).Communication scientists recognise that communication occurs at multiple levels of a social ecological system, namely, intrapersonal (the realm of emotion, cognition, and decision making), interpersonal (the realm of social relationships), networks and organisations (the realm of norms and social structures), as well as macro societal (the realm of large social systems and culture) (Storey et al 2014).

Health and medical establishments have intensive needs to communicate with current and prospective audiences to address the health concerns of the target community (Elrod & Fortenberry 2018:3). Communication is part of medication in the healthcare industry. Health professionals cannot avoid communication while undertaking health campaigns. Understanding health communication helps improve societal health. Health communication and risk communication in public health emergencies, including pandemics, aim to improve health outcomes by influencing, engaging, and reaching out to different at-risk audiences with health-related information (WHO 2017).

However, the role of health communication has not been conceptualised systematically across the stages of this continuum: taking advantage of what communication science indicates are appropriate and effective applications in other areas of health (Storey et al 2014).The inability to understand the role of systematic and strategic communication affects HIV/AIDS message delivery (Storey et al 2014). The Healthy People project in the United States of America (USA) (2010) reported that health communication contributes to health promotion and is something that health professionals should understand.

Health behaviours and outcomes are influenced by communication (Ishikawa & Kiuchi 2010:1). Healthcare workers need to have effective communication skills to deliver the necessary health messages. In Ethiopia, health communication does not adequately recognise the contexts of the specific population in the local areas. The FHAPCO report (2011:30) shows that the lack of a comprehensive and coordinated communication framework challenged the campaigns against HIV/AIDS (Serbessa et al 2016:2). There have been deep-rooted problems in recognising the intended targets to alleviate HIV/AIDS challenges in the developing countries (UNAIDS 2013:7). Health programmes need to integrate with the local contexts for effective HIV/AIDS prevention.

Most countries across the world understand the importance of integration to curb the spread of HIV/AIDS (UNAIDS 2013:8). However, there are remaining tasks concerning these integration endeavours. Having a greater number of sexual partners has been on the rise in some African countries like Burkina Faso, Congo, Cote d'Ivoire, Ethiopia, Gabon, Guyana, Rwanda, South Africa, Uganda, the United Republic of Tanzania, and Zimbabwe (UNAIDS 2013:14). This is attributed to their socio-cultural issues. Social behaviour, which is part of culture, determines health campaigns such as the communication against HIV/AIDS (UNAIDS 2013:14). The National Reproductive Health Strategy of Ethiopia (2005–2015) highlights BCC activities concerning health and is viewed as urban-focused and not locally contextualised. Inadequate coordination in HIV/AIDS service provision thwarts attempts to provide uniform and contextualised services across the country.

HIV/AIDS prevention strategies should be linked to other reproductive health activities through both the private and public sectors. HIV/AIDS communication among the Borana pastoral community should coincide with the lived experiences of the community. The target community should be able to receive clear messages that are relevant to their contexts. Effectiveness of health communication includes understanding the specific contexts of the target population (Olaoye & Onyenankeya 2023).

A systematic review of health communication strategies in sub-healthcare workers, as well as development partners working on societal health, should note the emerging issues of health communication that gives emphasis to the socio-epidemiological aspects of health behaviour. When public health professionals provide services to improve the health of the communities, there is a risk that their aspirations and values will conflict with the target community's values (Banwell, Ulijaszek & Dickson 2013:49). Health professionals who are familiar with the local culture can provide appropriate services. Professionals who belong to the same culture may have a good understanding of the target population compared to professionals who have no inherent relation and affiliation (Banwell, Ulijaszek & Dickson 2013). Health professionals, whether they belong to the target community or not, need to be aware of the Indigenous contexts of the target population; this is to provide appropriate healthcare and treatment.

Disease prevention should consider the social and behavioural aspects of the specific community (Ilwoo et al 2023). HIV/AIDS communication needs to address the social and behavioural contexts of the Borana pastoralists. These contexts broadly include the totality of life of the target community at bottom level. Health communication is not only about medical epidemiology but also about the socio-epidemiological aspects that give emphasis to the social contexts in disease prevention, care, and treatment. However, Vermund and Hayes (2013) point out that the vital roles of socio-cultural contexts within health communication in developing countries such as Africa have been overlooked. To ensure that health is addressed in communication, catering to societal factors such as cultural values, norms, belief systems, religion/spirituality, gender, and the day-to-day life experience of the society is crucial.

Culture plays an imperative role in its members' survival and health (Goodwin 2015:12). Cultural tools and processes help people to interpret and understand the world. Social norms, beliefs, attitudes, spiritual and emotional explanations, as well as practices contribute to peoples' understanding of the world in which they live. The social stratification process affects life opportunities at group and individual levels of the health decision-making ability (Goodwin 2015:12). Every cultural group develops and maintains a social structure that defines and coordinates the numerous roles and relationships of its members (Goodwin 2015:12-13). Thus, culture affects the way in which people make health decisions. Social groups construct their own meaning based on their specific identities which could include culture, language, gender, religion, race, or gender realities.

Health communication is effective when the message is close to the culture, expectations, and lifestyle of individuals (Alves & Oliveira 2018:183).

Effective and contextualised communication is a decisive element of international efforts in health communication (Ilwoo et al 2023; Airhihenbuwa 2000:2). Effective health communication is a primary weapon in preventing the spread of AIDS (Wanyoike 2011:88). For instance, effective HIV/AIDS campaigns are based on relevant information and knowledge about the specific population. Scientific knowledge about HIV/AIDS brings the intended change when it considers people's behaviour. The personal relevance of health communication and socio-cultural factors may also strongly affect an audience's response to health communication (Wanyoike 2011). Knowledge and information about a given disease should consider the social realities. The concept of Indigenous communication should operate properly to deliver effective health communication. Effective communication is possible through understanding and utilising resources in the community that would promote health messages (Wanyoike 2011). Healthcare workers should clearly understand and utilise cultural resources such as language, values, norms, belief systems, and religion in the community to foster effective health communication (Corcoran 2007).

Health communication in the developing countries should integrate with the community's contextual domains like culture, religion, spirituality, language, values, norms, and lived experience of the target population (Prilutski 2010:3). The principles of inclusion and participation help to overcome problems concerning health message conceptions (Ford et al 2005). Health problems with increased comprehension include the fact that just understanding an issue does not lead to a change in behaviour and that awareness alone does not hold people responsible for their own health. Health communication is more effective when the target population has input on how the health communication is going to help them change (Anugwom 2020). It empowers the community when the communication approach is bottom-up. Bottom-up communication encourages the use of Indigenous resources and channels to foster societal health. Health communication concerning HIV/AIDS should not only consider the knowledge and information about the disease, but also the socio-cultural assumptions that influence peoples' knowledge and attitude towards the disease. HIV/AIDS communication among the Borana pastoralist community is an area that will be investigated in this study. Serbessa et al (2016) reported that the Borana pastoralist community lacks HIV/AIDS knowledge and awareness. HIV/AIDS communication skills in the cultural community of sub-Saharan Africa are low, which negatively affect the communication at family, community, and society levels (Bastien, Kajula & Muhwezi 2011).

From the existing literature, it is possible to deduce that the issue of health has reached beyond the medical field.

Contextualised communication is required to address health messages (like HIV/AIDS messages) effectively among the Borana pastoral community. Healthcare workers should understand and utilise the cultural resources in the target community to communicate health information effectively. Tailoring health communication and health campaign strategies to the contextual domains of the target community is an emerging approach that can be applicable to developing countries, including Ethiopia. The findings of this study (see Chapter 6) also indicated that there is a communication problem with addressing the HIV/AIDS issues effectively among the Borana pastoralist community. The United Nations Development Programme (UNDP)'s assessment of community conversation practices in Yabello, one of the districts in the Borana zone, documented low levels of knowledge on the modes of HIV infection and subsequent denial of the existence of HIV (Miz-Hasab Research Centre 2004). Distribution of health services is restricted to small urban settings in Borana. Health service delivery, including HIV/AIDS services, in Borana is not contextualised to the nature of the pastoral community. As a result, comprehensive knowledge about HIV transmission and prevention is only approximately 5% among the pastoral community (Mitike et al 2002:6). Therefore, HIV/AIDS in Borana is at a critical state where extramarital sex is still actively engaged in. This puts the community at greater risk of HIV infection and calls for an immediate and focused intervention, guided by the realities on the ground and tapping into available cultural resources. The communication approach should line up with the situational and demographical factors that may influence message reception. The next section explains health communication campaigns as well as the essential components which need to be considered while undertaking these campaigns.

3.4 HEALTH CAMPAIGNS: HEALTH MESSAGE CONSTRUCTION, AUDIENCES' REALITY, AND CATERING FOR SOCIO-CULTURAL INCLUSION

Health campaigns are only one aspect of health communication approaches (Dastmanesh, Karimi & Ghahremani 2023). In the context of HIV/AIDS, health campaigns are public awareness drives to influence behaviour change and encourage openness, increase access to voluntary HIV testing and counselling, promote increased condom use to reduce the spread of STDs and HIV infections, and to improve the treatment of people living with AIDS. Culturally competent HIV/AIDS campaigns reflect an understanding of the audiences' unique

worldview, particularly as it relates to their perception of health, which may be reflective of their cultural background and norms, their health literacy, and their ability to access services. The effectiveness of health campaigns depends on addressing the interest of the target audiences (Ahmad 2012).

Culturally responsive health promotion initiatives are important to the Indigenous populations (Okoro et al 2020). Knowledge and utilising the cultural resources within the community is crucial to address effective health messages (Looket et al 2023). Health promotion contributes to health behavioural changes in the form of health campaigns (Whitehead 1997). Health promotion should include setting proper objectives, identifying target audiences, identifying resources, constructing messages, choosing appropriate channels of communication, implementing, and evaluating the results (Ahmad 2012). Communication planning plays a crucial role in effective health campaigns. In addition, the success of the health campaign depends on the community and the opinion of the leaders' participation. Effective health communication campaigns provide a forum of discussion. It creates a supportive environment and knowledge about the health services available in the target population. Moreover, effective health communication campaigns put health issues on the agenda and mobilises the society towards the intended behavioural change (UNAIDS Global Media AIDS Initiative 2004). Health campaigning, in the context of a communal society such as the Borana pastoralist community, should focus on the interactions and communication with the target community to develop their own health.

3.4.1 Health communication campaigns

Communication campaigns are purposive attempts to inform or influence behaviours in large audiences within a specified timeframe using an organised set of communication activities and featuring an array of mediated messages in multiple channels, generally to produce non-commercial benefits for individuals and the society (Zhao 2020).Health communication campaigns have made important contributions to the advancement of public health globally and are often considered critical components of broad intervention efforts, such as cancer and tobacco control (Zhao 2020; Rice & Atkin 2012).

Public health campaigning has been used for several decades to promote awareness and understanding of health issues and to mobilise action (De Morais Pinto et al 2021). Campaigns aim to promote awareness, increase knowledge, and encourage a target

population to adopt desirable attitudes and behaviours (De Morais Pinto et al 2021). However, assessing message reach from multidimensional perspectives, such as the socio-cultural context, can facilitate the development of more effective campaigns in public health response (De Morais Pinto et al 2021). This is because cultural differences could pose challenges for global public health campaigns, which use cognitive or affective goals to evoke desired attitudes and proactive health-promoting actions (Zhang et al 2021). Historically, health campaign programmes have operated independently from each other, often with limited coordination across programmes and within a country's health system. This has resulted in inefficiencies and inequities that can burden healthcare workers and limit the potential impact of these important health interventions.

The most carefully crafted campaign messages are useless if they do not reach and engage the target audiences (Zhao 2020). Channels for campaign message dissemination include various forms of media, interpersonal networks, community settings, and promotional events, among others. Traditionally, large-scale campaigns have relied on mass media, particularly television, as the primary vehicle for message delivery. With the advent and rapid development of social media, campaigns have become increasingly creative and diverse with their channelling strategies, hoping to tap into the vast potential of these new media platforms (Zhao 2020). The design of population-specific health messages and the channelling of communication can positively influence the audiences' health behaviour. Considering elements like proximity, concreteness, repetition, familiarity, simplicity, activity, visual and clear contents, elite personalities, as well as messages with effective content and humour is essential to attract audiences' attention (Rice & Atkin 2012). In addition, health communication campaigns that are intended for the maintenance of good health and preventive measures may not be successful if there is a language barrier (Timmins 2002). Language provides meaning, relation, interrelation, fosters self-reflection on the past, and critical thought. It plays a guiding role in the maintenance or alteration of the community's social fabric (Dugassa 2006:4). Health messages, including HIV/AIDS messages, must be developed in a familiar language that is accepted by the target audience. The language consideration serves to eliminate the alienation of the health messages, make the messages culturally appropriate, as well as geographically and educationally more understandable and acceptable (Usonwu et al 2021). A health communication campaign should adhere to the audiences' level of literacy (Wilson et al 2003). Developing educational strategies that are appropriate for lower-literacy audiences and culturally sensitive communities would result in positive health behaviour. Understanding the literacy situations of the target community helps to design health messages (Rice and Atkin 2013; Wolf et al 2006).

Considering the socio-cultural and demographic contexts of the audience is essential as health messages receptions can be influenced by various factors like the demographic profile, language, education, profession, age, and other geographic profiles (Usonwu et al 2021). The construction of HIV/AIDS messages and the selection of media depend on the proper identification of the target audiences. Therefore, HIV/AIDS communication among the Borana pastoralist community should consider the contexts of the target audiences to address appropriate messages. The communication campaign needs to consider factors such as the socio-cultural context, language, communication materials, visual resources, literacy, communicators' personality, and content, as well as demographic profiles of the target population.

Communication content plays a key role in promoting the audiences understanding. HIV/AIDS communication content should be useful to encourage positive practices in the target community. The message should enhance the knowledge of the target audiences, otherwise they would not be interested in information they already have (Usonwu et al 2021). Message reliability and effectiveness can be enhanced using two-way communication. Two-way communication between health professionals and the target audiences encourages message receptivity (Usonwu et al 2021). In this regard, HIV/AIDS messages must be considered useful to promote acceptance of innovative ideas and/or practices, methods, and to increase the knowledge and retention ability of the audiences (Usonwu et al 2021). HIV/AIDS communication campaigns in the Borana pastoralist community should consider the socio-cultural context of the local community. The message design and channels should be suitable to the pastoralist livelihood and lifestyle. This means "one size fits all" approaches of HIV/AIDS communication campaigning cannot address the real issues of the pastoralist community.

Health communication materials are expected to enhance the credibility and acceptability of health messages (Usonwu et al 2021). Contextualised communication materials make health messages understandable. Additionally, such contextualised materials provide details. Materials that consider the realities in the target community help both the service providers and the target audiences. Furthermore, contextualised communication materials that are based on illustrations and case histories for instance, have a greater impact than statistical or other data summaries (Usonwu et al 2021). Materials used in health campaigns, including HIV/AIDS campaigns, should be contextualised in line with the audiences' socio-cultural reality (Rice & Atkin 2012) and should be accepted by the local audiences. The campaign strategies need to utilise the local resources that are familiar to the Borana audiences.

Health messages are credible if it engages and empowers individuals and communities to choose healthy behaviours and make changes that reduce the risk of developing diseases and other morbidities. This can be applied to the Borana pastoralist community where HIV/AIDS communication and the campaigning strategies did not effectively engage the community in the local areas.

The use of visuals makes messages more attractive and impact oriented. According to an old Chinese saying, “one picture has left more impact on audiences than one thousand words” (Usonwu et al 2021). The use of visuals enhances message retention. Culturally relevant visual aids in health communication help to overcome language barriers, especially in societies where the literacy rate is low. In addition, visual symbols would help to leave long-term impacts on the memories of individuals (Usonwu et al 2021). The Borana pastoralist community is endowed with cultural resources although they have less exposure to modern education. As a result, orality dominates. Health campaigns including HIV/AIDS communication in Borana need to use concrete examples such as visual aids to contextualise health messages to the pastoral community. In HIV/AIDS communication campaigns, using famous people, like cultural leaders, play a significant role in creating a positive emotional appeal for dispelling the ignorance of the public and removing social stigmas related to this disease (Usonwu et al 2021). Public figures, like the cultural leaders and religious leaders, can play a vital role in creating awareness in HIV/AIDS prevention programmes for the Borana pastoralists. Positive emotional appeal can motivate the audiences to accept health messages that would lead to positive behavioural change. HIV/AIDS communication among the Borana pastoral community needs to use public figures such as the *Gadaa* cultural leaders, elders, and religious leaders to encourage positive behavioural change in the local community. The opinion leaders would help to communicate contextualised health messages and attract audiences’ attention for positive social behavioural change.

Contextual factors, like the customs and beliefs of individuals, influence their ability to accept, interpret, and act on health information (Yeo et al 2018). Differences and similarities among cultural groups should be considered in health communication campaigns. This is because a socio-cultural understanding improves communication between people from different cultures. Cultural exchanges foster greater trust among the people of different cultural backgrounds (Usonwu et al 2021). Health message designers need to consider the diverse variables like socio-cultural, linguistic, gender, religious, education and other socio-demographic contexts in the community for effective messages delivery.

Therefore, healthcare workers and the stakeholders should understand the socio-cultural and religious situations in the target population for health message effectiveness.

3.5 INDIGENOUS BELIEFS AND PRACTICES IN HEALTH COMMUNICATION

There are local beliefs and practices such as healing rituals, traditional medicine, Indigenous knowledge, as well as religion/spirituality that play a vital role in a community's health development (Mwaka, Achan & Orach 2023; Workneh et al 2018). The following sub-topics discuss healing rituals, traditional medicine, Indigenous knowledge, and religion/spirituality with respect to the focus of this study.

3.5.1 Healing rituals and traditional medicine in Africa

African traditional medicine contributes to greater healthcare coverage by providing primary healthcare to rural dwellers who often have limited access to modern medical services (Manqele, Selier & Downs 2023). Traditional healers have been proposed as a community-based strategy for enhancing the HIV care. The cascade HIV/AIDS treatment is highly associated with traditional cures in Africa. This implies that in the cultural society of Africa, traditional healers are respected and can therefore strongly influence the behaviour of people in their respective societies. For instance, in some African countries such as Mozambique, traditional doctors have been reluctant to participate in government programmes aimed at increasing awareness of the seriousness of HIV/AIDS (De Graca 2002:23). However, in other African countries like South Africa, traditional healers receive training to support the government to promote societal health (Shizha & Charema 2011). In Africa, people seek hospital care only when they are seriously ill (Flint 2015). Medical care is not sought early during the disease, and this negatively impacts the treatment of HIV and AIDS (Flint 2015). Using traditional healers has been associated with delays in HIV diagnoses, leading to reduced antiretroviral adherence among people living with HIV. Some traditional healers believe that there is no HIV and this impact negatively on the management of HIV as they end up manipulating their clients into believing that they can heal them. Seeking healthcare services from traditional healers is an alternative (i.e., used in place of conventional treatment) and complementary (i.e., used alongside the conventional treatment) approach to the treatment of HIV/AIDS (Chinsembu, Syakalima & Semenya 2019).

The use of herbs, spirits, or a combination of both, provide healthcare and manage concerns about HIV/AIDS. Healing rituals are used to promote health behaviours of people (Shizha & Charema2011). Healing depends on a meaningful and convincing discourse that transforms the patient. Traditional healing remains an important aspect of many people's engagement with healthcare (Flint 2015). However, there has been much debate on the value of customary healing practices concerning chronic diseases like HIV/AIDS. Increasing the traditional healers understanding of HIV/AIDS and securing their participation to effect positive changes in behaviour remains a big challenge in Africa (De Graca 2002:23).

Flint (2015) states that culturally bound communities in Africa are more open to the role that traditional healing can play. Traditional approaches to healing are considered acceptable. However, it might be contentious; especially where the treatment of a chronic disease is concerned (Flint 2015).In Ethiopia, there is a high tendency to listen to traditional doctors to cure illnesses like HIV/AIDS. Faith healing is widely used for the treatment of HIV-related illness due to the long history, prevailing illness perceptions, and religious beliefs (Kloos et al 2013:7). People are observed while receiving advice from spiritual fathers who overlook medical treatment in curing chronic diseases like HIV/AIDS (Kloos et al 2013). Increasing evidence of positive outcomes of faith healing involving holy water and prayer reported by PLHIV has potential application for chronic patient care but needs further study (Kloos et al 2013).

Gyasi et al (2011:2) explained that traditional medicine reflects the socio-religious structure of Indigenous societies from which it developed, together with the values, behaviours, and practices within their communities. In Africa, patients consult both the biomedical doctors and traditional healers for all kinds of physical, emotional, and spiritual illnesses (Kloos et al 2013). Health communication regarding HIV/AIDS needs to consider the role of traditional healers and spiritual leaders. There should be collaboration between the traditional and biomedical health sectors (Zuma et al 2018). However, biomedicine has been criticised in Africa for overlooking the relationship of the social and spiritual being to the body and the effect the former has on the latter.

Western medicine or biomedicine is often contrasted with the approach taken by traditional medicine practitioners. Biomedicine is usually associated with diseases of the physical body, which is only based on the principles of science, technology, knowledge, and clinical analysis (Shizha & Charema 2011). Biomedical approaches and traditional healing systems that incorporate spiritual healing, as well as physical and social healing, play a crucial role in

health delivery systems (Shizha & Charema 2011). Thus, an integrative approach has been accepted as a vital component of holistic healing. HIV/AIDS communication with the Borana pastoralists should understand the role of traditional healers. In addition to the medical approaches of HIV/AIDS prevention, there is a need to promote socio-cultural approaches of HIV/AIDS communication that considers the local contexts. There should be collaboration among the medical professionals and traditional healers to promote societal health concerning HIV/AIDS.

In sub-Saharan Africa, the use of herbal medicine, certain foods, faith healing, and other Indigenous health resources for HIV/AIDS treatment is widespread (Kilos et al 2013:2). Traditional healers, religious leaders, herbalists, households, and some drug retailers use a wide range of herbal treatments for their health. In rural communities in Ethiopia, traditional medicine continues to remain a vital and permanent part of the people's own healthcare system. Despite western medicine becoming more widespread in Ethiopia, the rural community tends to rely more on traditional medicine (Wassie et al 2015:1). The modern health services in Ethiopia are concentrated in the urban areas. Rural people in Ethiopia tend to use traditional medicine due to their lack of access to modern healthcare facilities. Traditional medicine is accessible and not as costly (Gakunga et al 2014). There is increasing evidence of positive beliefs in faith healing involving holy water and prayer in Ethiopia to cure chronic diseases. Particularly, PLWHV depend on faith healing to get spiritual and mental benefits, although it requires further study (Mwaka, Achan, &Orach 2023; Kahissay, Fenta, & Boon 2020; Kilos 2013). A growing number of people living with HIV/AIDS in Ethiopia today are relocating to holy water sites, in search of spiritual care. Knowledge about the traditional medicine in Ethiopia is still limited (Wassie et al 2015: 2).

The issue of traditional medicine was not properly addressed in the national health system. Bio-medically trained healthcare workers should not underestimate the value and importance of traditional healthcare workers, the integration of the latter into the mainstream healthcare system will resolve not only issues related to health equity, but also lead to the efficiency of the true Africanisation of healthcare services (Ndlovu 2023:2). The impact of traditional medicine and faith healing should be properly considered for effective HIV/AIDS communication. HIV/AIDS communication approaches should promote the audiences' understanding concerning traditional medicine and its effect on societal health. The next sub-section explains the role of Indigenous knowledge in terms of HIV/AIDS communication.

3.5.2 Indigenous knowledge (IK)

Pophiwa and Saidi (2022) stated that Indigenous peoples are the holders of unique languages, knowledge systems and beliefs, and possess invaluable knowledge for the practices of positive health behaviour. It is also indicated that IK-based policy formulation and developmental agendas such as health are sustainable in the sense that Indigenous people will be encouraged and begin to accept development ideas; they will become fully involved during the implementation and the evaluation processes (Ned, Kpobi, & Ohajunwa 2021; Pophiwa & Saidi 2022).Indigenous knowledge is crucial to develop local solutions in health (Chinsembu, Syakalima & Semenya 2019). Mokhutso (2021) stated that health narratives are embedded in the unique set of Indigenous knowledge and experiences of the target community (Owusu-Ansah 2013).

Health communication, including HIV/AIDS communication, need to consider the Indigenous knowledge and contexts of the community. This knowledge is locally situated and relates to a set of common socio-cultural values and practices of the local community. Indigenous knowledge can be taken as traditional knowledge, folk knowledge, or ancient wisdom. This knowledge is embedded within the community's practices, institutions, relations, and rituals. IK forms the base for societal health, which facilitates communication and decision-making (Rankoana et al 2015).

In addition, IK shapes local visions and perceptions of a society (Rankoana et al 2015). It has long been marginalised by western knowledge systems in the search for sustainable solutions to developmental challenges, including mitigating the challenges of health equity and public health (Ndlovu 2023). This is due to the dominance of the western knowledge system and its wide acceptance. Younger generations who value more western values and lifestyles are being oblivious to the moral, psychic, and spiritual character of IK (Ndlovu 2023). This means communities and groups that adhere to traditional practices and belief systems are represented as ill-educated, backward, and even uncivilised (Ndlovu 2023). Indigenous systems of health knowledge and healing practices must meet the needs of the local communities. Sharing IK within (and across) communities can help to enhance cross-cultural understanding and promote the cultural dimensions of development. Tailoring HIV/AIDS communication to the IK of the Borana pastoral community would help to use the positive aspects of the existing knowledge to control the spread of HIV/AIDS.

3.5.3 Religion and spirituality

Golo and Novieto (2022) indicated that religion has most often been considered as anti-developmental activities and posing impediments to development and therefore divorced from development theory, policy, and practice. Freeman (2015:114) pointed out that in the developing world, the development community such as faith-based organisations and many other non-governmental organisations in humanitarian and development work, have shifted their focus and emphasis on “macro-scale economic matters” and begun shunning socio-cultural contexts such as religion in development thinking. According to Freeman (2015:114), the focus given to the religious aspect of development is due to the acceptance by most development policy makers that “development can be achieved only if people build on their resources” (Golo &Novieto 2022).

In the developing countries, like Ethiopia, religious/spiritual beliefs and practices have contributed to the creation of social stability. Religious beliefs and spiritual practices may influence individuals’ health behaviour (Koenig 2012:1). “Spirituality is more individualistic and self-determined, whereas religion typically involves connections to a community with shared beliefs and rituals” (Koenig 2012). There is an overlap between religiosity and spirituality; more of the patients consider themselves both religious and spiritual. In the case of a population that has often faced stigmatisation by institutionalised religion due to HIV/AIDS, it is important to differentiate religion from spirituality. Religious activity is a behavioural reflection of internal spiritual beliefs (Pargament, Ano & Wachholtz 2005). “Spirituality may refer to subjective inspirational experiences that give everyday life a sense of deeper meaning” (Emmons 2003). Promoting healthy behaviour requires understanding how religion and spirituality influences health through psychological, social, and behavioural pathways (Tricco et al 2018). Religious beliefs and practices are associated with greater well-being, hope, and optimism (Koenig 2004). The religious and spiritual practices of the target community need to support the campaigns against HIV/AIDS. HIV/AIDS communication in the Borana pastoralist community should address the religious, as well as spiritual, aspects of the epidemic that resonate within the cultural group. The following topic presents the importance of a shift in health communication.

3.6 SHIFTS IN HEALTH COMMUNICATION PERSPECTIVES

Health communication in the 1960s was characterised as the “medical era” (Rampton, Böhmer & Winkler 2022:343). The health communication was operated under the assumption that, “If we build it, they will come”. In the 1970s however, there was a shift in communication from medical centres to the field. The health philosophy to move from health centres to the field was borrowed from the agricultural extension model. The fieldwork was mostly supported by printed materials and visual aids. This period was described as the “field era”, moving from monologue to dialogue (Rampton, Böhmer & Winkler 2022:343). On the other hand, the 1980s saw the proliferation of social marketing that enforces customers to ask and pay for services. This era paid attention to the application of social marketing. The integrated marketing communication approaches were borrowed from the commercial sector. The period of social marketing was termed the “social marketing era”. Health communication in the 1990s to date has evolved into what may be called the “strategic era”. “The strategic era is characterised by a multi-channel integration, multiple stakeholders, increased attention to evaluation, evidence-based programming, and a communication process in which participants (senders and receivers) both create and share meanings together” (Rampton, Böhmer &Winklerl 2022:7). The shift in the strategies of health communication shows that there is a need to promote an approach that is suited to the user’s reality. It implies that communication in health is not only about the medical aspect, but that the human aspects should also be considered.

The change in thinking in health communication from a solely epidemiological focus to an integrated socio-epidemiology focus plays a crucial role in addressing public health properly. Audiences differ in their assumptions, attitudes, self-efficacy, and receptivity to messages. “Biometrically oriented scientists and clinicians feel that they are poorly informed about the technical aspects of modern health communication” (Gupta, Jai & Yadav 2021:95; Schiavo, May Leung & Brown 2014:76; Vermund, Van Lith & Holtgrave 2014:2). Health communication has become a crucial concern in the healthcare industry. The health content, medium, and style of the messaging must suit the different socio-cultural contexts (Vermund, Van Lith & Holtgrave 2014:2). Medically oriented health professionals overlooked the importance of behavioural domains to promote societal health. Social epidemiology is an emerging landscape with many avenues of synergy (Agustina et al 2023:178; Whitelaw& Clark 2019; Vermund, Van Lith & Holtgrave 2014:2). “The recent paradigm of combination prevention, which integrates behavioural, biomedical, and structural interventions, offers new

opportunities for employing health communication approaches across the entire continuum of care" (Tomori et al 2014:1). For this study, HIV/AIDS communication among the Borana pastoralist community is expected to integrate the medical and behavioural aspects of disease prevention. Promoting the integration of medical epidemiology with the behavioural domains of the target community, such as the socio-cultural context, is crucial. The next section discusses the growing role of culture for health interventions.

3.6.1 Emerging role of culture in healthcare contexts

The National Institute of Health (NIH) (2015:26) identified that huge gaps exist concerning the role of culture in health. The concept of culture is inadequately conceptualised and inconsistently applied in health issues (NIH 2015). In addition, there is insignificant work that demonstrates how culture affects health outcomes (Cogburn 2019:736; Mekonnen & Yenealem 2019:185). The NIH (2015:26) stated that problems of diverse cultural groups are identified, but devoid of their historical, geographic, social, and political contexts. These contextual factors influence people's positions in the societal power hierarchy.

The dynamic nature of culture is not reflected in most studies, including human health. Culture enables group members to make sense of their world and to find meaning in — and for — life (Kagawa-Singer et al 2015:11). According to the Department of Health and Human Sciences (DHHS) (2013:5), health communicators should recognise the nature of human communication that occurs at multiple levels (interpersonal, group, public, and mass) and social systems such as micro and macro social systems. Health communication in the socio-cultural perspective should consider what is shared and what is specific, what is new to the existing culture and what is temporally embedded among a community (Banwell, Ulijaszek & Dickson 2013). Health relevant cultural processes, or modes of shaping practices, can be widespread. Therefore, the cultural processes are manifested differently depending on local, historical, and social contexts and environmental conditions. To communicate health matters, it is necessary to understand the perspective of people in the context of their everyday lives if an intervention is to be successful. People do not easily relinquish their beliefs and practices, which are often sensible and functional, because they are told to do so for health reasons (Banwell, Ulijaszek & Dickson 2013:345). Healthcare professionals among the Borana pastoralist community should be aware of the emerging role of culture in the healthcare industry and properly utilise it for better societal health. The next topic presents the rationality behind integrating cultural values with health issues.

3.6.2 Rationale for a culture–health integration

The rationale for culturally appropriate and tailored health promotion programmes stems from four observations. This includes changes in the demographic composition of a population, the differences in disease prevalence rates across racial/ethnic groups, differences in the prevalence of behavioural risk factors across racial/ethnic groups, and differences in the determinants of health behaviour and behaviour changes across groups (Edgar, Noar & Freimuth 2008:194).HIV/AIDS communication should consider the PEN-3 cultural health model (Chapter 3,Part II) which states that HIV/AIDS prevention in Africa should be tailored to the socio-cultural contexts of the specific community (Khandu, Tobgay & McFarland 2020; Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa 2007a). In addition, the multiple domain model discussed in Chapter 3, Part II, explains that HIV/AIDS prevention is influenced by the contextual factors of the individual. Thus, the national HIV/AIDS should address the socio-cultural, gender, religious/spiritual, demographical, environmental, and contextual variables in the specific population group (Zimmerman, Christakis & Meltzoff 2007). Edgar, Noar & Freimuth (2008) added that the demographic composition is the description of the population defined by characteristics such as age, race, sex, or marital status. In addition, health behaviours are influenced by the social, cultural, and economic circumstances that frame and constrain them, which may significantly vary across diverse racial/ethnic groups. Racial disparities in health have been well noted, with black individuals having poorer health than white individuals across a broad range of outcomes (Williams & Sternthal 2010). Behaviour is affected by factors relating to the person. Physical factors can be age, health, illness and pain, or the influence of a substance or medication. Personal and emotional factors are: personality, beliefs, expectations, emotions, and mental health. Life experiences include family, culture, friends, and life events (Edgar, Noar & Freimuth 2008). It is indicated that factors such as place of residence, environment, genetics, income, education level, and relationships with friends and family all have considerable impacts on health (Edgar, Noar & Freimuth 2008). Thus, understanding the determinants of health behaviour provides the basis for tailoring — adapting programmes and messages for sub-populations.

Health programmes and message design must be adapted to a community's unique characteristics (Edgar, Noar & Freimuth 2008:195). This means, programme developers must vary the behavioural focus, the essential message strategies, the channel choices, and the message excisions in the heterogeneous sub-population group.

The need for tailored interventions is determined by the degree to which the target audiences may be motivated by culturally specific message content, format, or channel of delivery (Institute of Medicine 2002:97). The rationale behind tailoring health programmes in relation to the contexts of the specific population group has remarkable value to communicate messages, including HIV/AIDS messages. The communication campaigns should be designed in such a way that the target pastoral community receive the intended health messages properly. HIV/AIDS communication among the Borana pastoralist community should address issues of socio-cultural and demographic contexts, as well as the environmental aspects of the local community for effective message delivery and social behavioural change.

Health content, medium, and style of messaging should be appropriate to the societal contexts (Vermund, Van Lith & Holtgravel 2014:1). Health decisions of a target community can be influenced by contextual domains such as “language, culture, religion, education, gender, age group, experience with the health topic in question, socio-economic status, level of trust, degree of social isolation or integration, and social norms” (Vermund, Van Lith & Holtgrave 2014:2). For effective health decisions in the Borana pastoralist community, it is crucial to link health communication to the socio-cultural contexts of the target population that shape a group’s behaviour in relation to key health messages (Dubé et al 2023; Campbell et al 2013). Involvement has been conceptualised in several ways by promoting active information processing through a central route (Dubé et al 2023). Uninvolved audiences access information in a passive fashion, which has been conceptualised via a peripheral route (Dubé et al 2023). Peripheral information processing lacks the active awareness, comprehension, and evaluation of arguments to support the position. The health message designer’s goal is often to prompt active thought in a passive audience. Audiences are more involved in the issues they are well informed about. A health topic that is not in the context of the audiences’ reality, may not invite audiences to participate.

In health promotion, message designers should consider how, when, and why people are exposed to health messages (Bedson et al 2021; Nabarro 2017). To actively process health messages, prompting bottom-up attention processing in contrast to top-down processing is essential. The message design should take the bottom-up approach. Health message designers should view health messages from the perspective of the target group. Audiences should be at the centre when designing and communicating health messages for HIV/AIDS and other general messages. Health communication should lead the target audiences to make informed decisions that would foster good health (Campbell et al 2013).

This implies that health messages must be culturally, demographically, and geographically relevant. Healthcare workers should tune health messages to the real contexts of the target audience to influence the behaviour of a community for positive health outcomes. These messages are expected to persuade the target audience to develop good health behaviour. However, messages designed to persuade can limit people's ability to make informed choices and may erode public trust in authorities, which in turn, can negatively impact compliance (Oxman et al 2022). Pak, McBryde and Adegboye (2021) indicated that persuasive health messages may contain a threat message and various cues. However, the intention should be to influence the target community to be acquainted with the intended positive health behaviour. It is crucial to understand that a persuasive health message needs to be targeted to the community to bring about the intended positive behavioural change (Peinado et al 2020; Wilson& Taaffe 2017). To bring about a positive health decision concerning HV/AIDS among the Borana pastoralists, health workers should focus on the commonalities in the target audiences. The communication context and messages must be user-friendly to encourage good health decisions that enforce positive practices (Peinado et al 2020; Wilson & Taaffe 2017).

3.7 HIV/AIDS POLICY AND THE PASTORALIST CONTEXT IN AFRICA

In Africa, insufficient attention is being given to the marginalised and poor regions (Jin, Restar, & Beyrer 2021; UNAIDS 2018; World Health Organisation 2018). The scope of HIV/AIDS-related studies in the pastoral communities of East Africa has been limited (Serbessa et al 2016). HIV/AIDS interventions in pastoralist regions of East Africa, such as Borana, were not well contextualised and integrated into the needs of those impoverished populations as well as national HIV/AIDS programmes (Serbessa et al 2016). Development interventions like the HIV/AIDS intervention programme in Africa have long failed to accommodate the needs and preferences of pastoralists (Rogers et al 2021). There should be collaborations between local and international organisations in designing and implementing HIV/AIDS programmes in the pastoralist community of Africa. In health policy, including the HIV/AIDS policy of Africa, operating within economic, political, and social spheres of the respective countries are crucial (Edwards & Barker 2014).Emphasising the social structure and power imbalances when it comes to the HIV/AIDS policy in Africa, has the added benefit of recasting HIV prevention as an attempt, not only to modify disease patterns, but also to mitigate social injustice and inequality (Sovran 2013).Social inequalities in the poorer and more marginalised groups, like the pastoralists, should be properly considered for effective HIV/AIDS prevention (Fauci & Lane2020; Sovran 2013).

Ethiopia has endorsed a national HIV/AIDS policy for the general population. However, the policy (as discussed in Chapter 8) did not consider the specific characteristics of a pastoralist population like the Borana. The PEN-3 cultural health model (Chapter 3, Part II) states that HIV/AIDS prevention in Africa should be tailored to the socio-cultural contexts of the specific community (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa 2007a).

African governments have the obligation to develop appropriate health policies and frameworks (Ramogola-Masire et al 2020; Church et al 2015). African Regional Economic Communities (RECs) treaties also focused on ensuring human rights, including the health rights of the people. Furthermore, the East African Community (EAC) agreement obliges its state parties to harmonise national health policies and regulations and promote the exchange of information on health issues (African Union Commission 2016). Developing an appropriate framework or guideline to ensure the right to access HIV/AIDS services at national level is essential. The Committee on Perception and Communication (National Cancer Institute 1989:12) further explains that health communication informs the citizens about health threats and the public's health rights. An information right is part of the fundamental human rights that encourage people to make appropriate health decisions. Hence, it is possible to infer that HIV/AIDS and human rights are interconnected in many ways. For instance, human rights violations increase vulnerability to HIV/AIDS (Weinreich & Benn 2004:50-51). The right to adequate treatment for HIV/AIDS is part of the fundamental human right to health. This implies that the health policy (including the HIV/AIDS policy) of Ethiopia needs to ensure the information rights of the target community through contextualised messaging. The pastoralist community in Borana should have the right to access suitable HIV/AIDS education, information, and communication. The HIV/AIDS policy must consider the realities of the community on the ground. Ethiopian governments, including the local administrative bodies of Borana pastoralists, have the duty to promote, respect, and protect human rights concerning HIV/AIDS prevention.

HIV/AIDS communication should not abridge human rights issues (OHCHR 2022; Mike 2020). The communication requires respecting societal values, norms, culture, traditions, and the wide range of contexts at the bottom. The HIV/AIDS communications policy need to utilise the positive cultural values, norms, and belief system that would help to combat the spread of HIV/AID in the community. Malpractices that would hinder positive health outcomes concerning HIV/AIDS communication should be systematically tackled. Effective communication has the power to bring policy makers, opinion leaders, and healthcare

workers together to collaborate in favour of HIV/AIDS prevention. Appropriate health policies and strategies contribute to increasing awareness of health issues in the local community. Hence, HIV/AIDS communication among the Borana pastoralist community should empower the target people to develop their own health with the help of a contextualised HIV/AIDS policy.

3.8 CONCLUSION

This chapter explained the importance of contextualised health communication in general, and specifically in HIV/AIDS communication, to foster effective public health services. The chapter presented the role of socio-cultural factors for effective health message transactions. The literature works discussed reveal that health messages, including HIV/AIDS messages, should be in tune with the socio-cultural domains of the target community. Understanding the culture, values, norms, belief system, language, gender, spirituality, religion, rituals, traditional practices, and day-to-day life of the target community is crucial to communicate HIV/AIDS messages effectively. HIV/AIDS campaigns in the developing countries are expected to address the Indigenous domains of the target population. Society has the right to access appropriate HIV/AIDS messages that suit the context of the target community. Health policies and strategies in developing countries, including Ethiopia, overlooked the Indigenous domains. Disease prevention strategies in Ethiopia, including HIV/AIDS strategies, focus more on the medical epidemiology. Medical treatment alone may not suffice in the campaigns to promote societal health. As a result, this led to a change in thinking about health development in the context of the developing countries. Public health campaigns, including HIV/AIDS campaigns, should integrate the epidemiological aspects with the socio-cultural aspects of the target community. HIV/AIDS communication in the Borana pastoralist community should consider the Indigenous socio-cultural resources in the local areas. The next chapter (Chapter 3, Part II) is the literature chapter focusing on HIV/AIDS communication models, theories, and frameworks commonly used in the healthcare industry.

CHAPTER 3 (PART II)
HIV/AIDS COMMUNICATION MODELS AND THEORIES

3.1 INTRODUCTION

In this chapter, key health communication models and theories are explained. The chapter explores the strengths and weaknesses of some of the behavioural change models and theories, and the contribution of these models and theories to HIV/AIDS communication. Most theories and models used in HIV/AIDS communication are based on social psychology which emphasises individualism. As a result, researchers — including communication and health scholars — are now questioning the supposed global relevance of these models and theories. There is a need to develop innovative theories and models that consider the regional context of the developing countries like Ethiopia. The domains of UNAIDS communication framework like culture, religion/spirituality, gender, and communication are in line with the PEN-3 cultural model and the multiple domain model that guide this study. Thus, health communication models and theories, which are applicable to this study, are discussed in this chapter.

3.2 HIV/AIDS COMMUNICATION STRATEGIES: EXPERIENCE AND GAPS

Effective communication strategies have become a critical component in HIV/AIDS campaigns. Emphasis has been given to communication strategies to address HIV/AIDS messages in effective ways. Regardless of the global effort, HIV/AIDS remains a serious concern (World Bank 2022; Mirkuzie et al 2021). This is because the epidemic has no cure. The existing literature shows that the HIV/AIDS communication strategy should be grounded in a sound theory so that the resulting framework is flexible enough for application in different regional and cultural contexts (Obregon 2010:53). The communication strategies should be applicable to the context of the target population. For more than two decades, HIV/AIDS campaigns have been using different communication strategies. HIV/AIDS communication strategies in Africa are based on the western social psychological models and theories which favour rational thinking and individualistic culture. These strategies range from a single universal approach to a multiple integrated approach in understanding health behaviours (Obregon 2010). Most western-oriented health models and theories that are used to guide HIV/AIDS programmes in the developing countries are not relevant to the local

context of the collectivist culture within Africa (Iwelunmor, Newsome & Airhihenbuwa 2014:2).

Western behavioural change models and theories for HIV/AIDS prevention were considered effective in the context of the developing countries. However, these theories and models were not developed for the developing countries like Africa (Iwelunmore, Newsome & Airhihenbuwa 2014:2). Health programmes in Africa, including HIV/AIDS programmes, are guided by the western-oriented behavioural models and theories. Behavioural models and theories are used in HIV/AIDS communication regardless of their suitability to the target population (Iwenlunmore, Newsome & Airhihenbuwa 2014:19). In developing countries within Africa, socio-cultural domains including tradition cultural values, norms, belief systems, religion, spirituality, gender, and lived experiences, play pivotal roles in the everyday lives of the society. Health behaviour models and theories help to explain why individuals and communities behave the way they do. Health planners can use these models and theories to increase the effectiveness of their programme design, implementation, and evaluation. Different models may be appropriate in different situations. There is no one-size-fits-all approach; each individual or community requires programming that is tailored specifically to their needs.

Undermining the socio-cultural domains in HIV/AIDS programmes impedes the effort to tackle the epidemic (Smith, Zhu & Fink 2019; Crosby & DiClemente 2018). These socio-cultural variables play a key role in disease prevention struggles (Iwenlunmore, Newsome &Airhihenbuwa 2013). Western-originated behavioural theories and models were focusing on individual behavioural change. According to Davis et al (2015) most theories applied to public health interventions tend to emphasise individual capabilities and motivation, with limited reference to context and social factors. However, it is stated that intervention effectiveness may be increased by drawing on a wider range of theories incorporating social, cultural, and economic factors that influence behaviour (Robinson et al 2021; Davis et al 2015). These models and theories are believed to be useful and relevant in western communities. The debate among scholars in the field of communication and cultural studies is that the western health behavioural models did not give attention to the socio-cultural issues in Africa. For instance, the seminal behavioural models and theories such as the health belief model, the theory of reasoned action, innovation-diffusion theory, social learning/cognitive theory, social marketing theory, trans-theoretical model, and multiple domain models were not developed from the perspective of the socio-cultural context in

Africa (Davis et al 2015). Applying communication models and theories that overlook the African contexts cannot bring the desired behavioural changes concerning societal health.

Due to the basic value differences between the western and African cultures, it is doubtful whether the western-driven communication models and theories will effectively address HIV/AIDS problems among the Borana pastoralist community. Intervention effectiveness is increased by drawing on a wider range of models and theories, incorporating social and cultural factors that influence health behaviour (Davis et al 2015:323). Assessing the appropriateness of the western behavioural models and theories to address HIV/AIDS messages in the context of Ethiopia is essential. As a result, it is important to discuss some western-originated health theories and models to analyse their socio-cultural relevance in the context of the developing countries, such as the study site.

Lack of contextual domains in HIV/AIDS communication necessitated a shift in HIV/AIDS communication strategies (Iwelunmor, Newsome &Airhihenbuwa 2014; Campell2003; UNAIDS 2000). Health communication strategies have become critical in managing public health issues across Africa (Olaoye & Onyenankeya 2023:10). Using a holistic or multi-pronged health communication approach that is context-specific and participatory could attract more uptakes of health messages (Olaoye & Onyenankeya 2023:10). HIV/AIDS communication strategies need to engage the local community for effective social behavioural changes (Obregon 2000:6). The forms and strategies of HIV/AIDS communication should be centred on the context of the target community. “The inherent nature of older forms of HIV/AIDS communication in Africa is educational-instructional as the message is conceived ‘outside’ the recipient community and then persuasively diffused to the recipient community in the hope that the message will result in behavioural change. The old form of one-way information dissemination was modelled on the ineffective modernisation approaches to development communication” (Burger 2015:201).

The HIV/AIDS communication strategy is expected to incorporate approaches of participatory communication. This means that the target community should have a voice in HIV/AIDS message production and the communication process (Tomaselli 2011:8). HIV/AIDS communication among the Borana pastoral community should make use of the Indigenous domains. The communication strategies and message designs should also be user friendly. Govender, Durden and Reddy (2010) stated that HIV/AIDS communication strategies should explore three different communication perspectives to address the epidemic.

The first perspective is a steady shift from total dependence on mass media to participatory communication. The second is a shift from individual behavioural change to social behavioural change communication. The third perspective is to consider HIV/AIDS not as a health problem, but a development problem. The argument holds the assumption that the change in thinking creates partnerships as an added communication strategy. Therefore, HIV/AIDS communication among the Borana pastoralists should consider the local channel of communication that promotes the participatory communication approach. The participatory communication approach, in the context of this study, would help the health professionals to address messages that are relevant to the context of the target pastoral community.

In African culture, the topics of sexuality, sexual relations, and sexual contexts are not freely entertained in the public discourse (Obregon 2000). Similarly, for the Borana pastoralist community, the issue of talking about sex is taboo. People cannot freely discuss sexual issues in public (Chala & Haro 2023; Takele 2020). In the Borana pastoralist community, open discussions of sexual matters among family members are not common. Sex is a topic of secrecy in the community (Chala & Haro 2023; Takele 2020). Making sexual issues secret has negative implications on the campaign to address HIV/AIDS messages effectively. As a result, the HIV/AIDS approach should be examined in relation to the Indigenous contexts of the target community. Imposing the western-originated individualistic health behavioural theories and models cannot bring change without understanding the contexts of African countries (Olaoye & Onyenankeya 2023:10). The cultural relevance of health theories and models should be considered in relation to the realities of the target community. Understanding culture is therefore vital for the effectiveness of HIV/AIDS programmes in Africa (Olaoye & Onyenankeya 2023). This can be applied to the contexts of the Borana pastoralist community where HIV/AIDS communication should consider the specific contexts in the pastoralist community.

The centrality of culture in HIV/AIDS programmes supports the intended social behavioural change. Okidu (2013:6) further explains that in response to the devastating burden of new cases of HIV infections in developing countries within Africa, the UNAIDS proved that the western behavioural models and theories alone were not adequate to address HIV/AIDS risks. Accordingly, a new communications framework for HIV/AIDS is necessary to direct focus away from the cognitive approach (which emphasises individual reasons) to the activity approach (which emphasises contextual factors). The redirection came up as a response to the shortage of the cognitive models/theories, which are narrowly focused on

the individual, with insignificant consideration to the contextual factors like socio-cultural environments (UNAIDS 2009).

Understanding message recipients is one often basic process in communication. This implies health communicators should consider the real contexts of the target audience. Not catering HIV/AIDS communication for the socio-cultural aspects among the Borana pastoralist community, affects message receptions. Furthermore, overlooking communication contexts and situations cripple communication effectiveness (Moola 2010). It is imperative to have a mutual understanding of the importance of context to promote good health behaviour. Individual-based HIV/AIDS communication models and theories have failed to serve the interests of the collectivist culture in the developing countries. The reports showed that individual-based health models and theories should reconsider the realities in the developing world (Davis et al 2015:323). Cognitive approaches alone could not address the problems of HIV/AIDS in the culturally bound society of Africa (Airhihenbuwa, Ford, &Iwelunmor 2014). Thus, by implication, the approach to address African health problems is through utilising Indigenous contexts in the local community (Airhihenbuwa, Ford & Iwelunmor 2014). For effective health communication, there is a need to shift from the cognitive to the socio-cultural context that solves health problems by understanding the real context of the target community (Airhihenbuwa, Ford & Iwelunore 2014). The next section presents health behavioural change models and theories.

3.3 HEALTH BEHAVIOURAL CHANGE MODELS AND THEORIES

Behavioural interventions aim to alter behaviours that make individuals more vulnerable to HIV/AIDS (Bhatta, Liabsuetrakul & McNeil 2017). Sexual behaviour is not a static phenomenon, but is influenced by many factors, including characteristics of the individual as well as their social and economic context. Behavioural interventions should be multidimensional. This implies that the intervention should consider not only the biomedical aspects, but also the socio-cultural aspects of disease prevention. To date, there has been a huge diversity of interventions, employing various methods that focus on the individual (Bhatta, Liabsuetrakul & McNeil 2017).

There is widespread agreement that the use of theory is central to developing effective behavioural interventions. Theory, in this context, refers to evidence regarding the social or individual constraints that either promote or inhibit behaviour change. Behavioural interventions for HIV prevention can broadly be classified as complex interventions — they

consist of separate elements that are combined for the intervention to function as intended and to deliver the desired outcome (Bhatta, Liabsuetrakul & McNeil 2017). People may respond differently to singular components and what constitutes the “active ingredient” may be different for each person (Joshi et al 2021). One of the great attractions of theoretical approaches is they can serve as a framework to enable a thorough consideration of which factors must be addressed to bring about the desired behaviour change, and how (Joshi et al 2021).

Theory-based HIV prevention interventions have been developed and implemented to reduce the risk of HIV infection transmission among young people and to enhance positive sexual behaviours. However, there is little evidence to suggest that highlighting the role of theory-based HIV and sexual health interventions has enhanced positive sexual behaviours among young people in sub-Saharan Africa. The worldwide attempts to slow the HIV epidemic have led to a clearer understanding that the battle is not simply about using condoms or adherence to medication (Belay et al 2022). HIV risk and AIDS care involve complex behaviours influenced from multiple levels: from an individual’s knowledge, attitude, emotions, and risk perception, to power dynamics between partners, accessibility of services, economic inequalities, criminalisation of vulnerable groups, and policies that make HIV a priority health issue (Bhatta, Liabsuetrakul & McNeil 2017).

Behaviour-based theories and models were useful and relevant for certain communities, specifically in the western world, to promote knowledge, a positive attitude, as well as positive behavioural change towards the HIV/AIDS epidemic (Iwelunmor, Newsome & Airhihenbuwa 2014:2). HIV/AIDS interventions should go beyond merely providing basic knowledge. Basic knowledge of the epidemic alone does not bring about the intended behaviour (Bandura 1994:25). “Behaviour-based theories became popular when information-only approaches made no headway. Greater understanding of the behaviours associated with HIV/AIDS transmission would more likely result in the adoption of HIV-preventive messages” (Muturi 2005:78). “Despite a marked increase in public awareness of HIV transmission, there has not been a corresponding change in high-risk behaviour” (UNAIDS 2004:17). Health communication theories that focus on individual behaviours are no longer effective to address the health problems of the collectivist cultural communities, like African nations (Bhatta, Liabsuetrakul & McNeil 2017).

This study recognises the need to shift health interventions like HIV/AIDS communication for the developing countries.

Health messages, including HIV/AIDS campaigns, should be tailored to the context of the target community. Health interventions that overlook the culture of the target community as well as what is not owned by the community, is seen as impositions by external bodies.

There has been consensus among experts on how to use the existing behavioural theories and models for HIV/AIDS prevention. This consensus emanated from two global consultative meetings and two regional meetings in Africa and Asia. The consultative meetings concluded that “the existing behavioural theories and models commonly used to inform HIV/AIDS communication are not adequate for the developing countries. This is because ‘the models and theories overlooked the use of context’. Disease prevention was based on rational thinking; single behavioural change such as the use of condoms was focused on, mass media was given attention, and assumed human behaviour could be changed through defined approaches of communication” (UNAIDS 1999c:15). Hence, HIV/AIDS prevention in developing countries should move away from highly individual-oriented interventions, informed by narrow psychological theories, towards more participatory and contextualised approaches. This can be applied to the Borana pastoralist community to bring social behavioural change. Seminal behavioural models and theories such as the health belief model, theory of reasoned action, social learning/cognitive theories, innovation diffusion theories, trans-theoretical model, social marketing, and multiple domain models are discussed in the following sections. These models and theories have been selected to confirm whether they are applicable in the context of the Borana pastoral community. The explanation of these models and theories, with their shortfalls, would help to propose a suitable approach in the context of the Borana pastoralist area. The critique for each model and theory are given in context to this study.

3.3.1 The health belief model

The health belief model is an individual-based model that supports behaviour change through rational thinking (Glanz, Rimer, & Viswanath 2015). This model argues that an individual’s perception and level of understanding influences disease prevention. This means people are rational and can prevent disease, based on the seriousness of the problem. The model explains and predicts health-related behaviour (Glanz, Rimer & Viswanath 2015). The health belief model has different constructs. These are perceived susceptibility, perceived severity, perceived benefits, and perceived barriers (Joorbonyan, Ghaffari & Rakhshanderou 2022).

Perceived susceptibility is seeing oneself as vulnerable to the disease. Perceived severity understands the severity and the seriousness of the illness. Perceived benefits relate to understanding the benefits derived from adopting preventative measures. Perceived barriers mean believing in the barriers to preventative measures (Joorbonyan, Ghaffari & Rakhshanderou 2022). In this model, the constructs: perceived susceptibility, perceived severity, and perceived benefits are all about individual behavioural change concerning HIV/AIDS. However, in the context of a collectivist society like Ethiopia, individuals are influenced by collective culture. Thus, HIV/AIDS communication should consider the collective context of the target community. HIV/AIDS prevention should consider Afro centric views of health development like the PEN-3 cultural health model that give focus to the contextual factors in Africa to promote positive health behavioural (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome &Airhihenbuwa 2014; Airhihenbuwa 2007; Zimmerman, Christakis & Meltzoff 2007).

The health belief model states that individuals are rational thinkers, and they can take actions that determine the likelihood of promoting good health behaviour (Honarvar et al 2022). The model has been in practise in the Ethiopian context through IEC and BCC, although it has limitations. It is based on individual behavioural change that cannot be effective in the collectivist culture of Borana. This model is also guided by the one-way communication and logical thinking behaviour of individuals. Most people do not approach HIV/AIDS issues from a logical perspective. This model assumes people have a built-in drive to pursue rational courses of action (Honarvar et al 2022). However, the model overlooks the past sexual experience, type of relationship among individuals, and self-efficacy of the collectivist culture (Kim & Kim 2020; Jones, Smith & Llewellyn 2014). It undermines emotional and situational frameworks within sexual activities, and it assumes that people are already aware of HIV/AIDS and its consequences. This model is not adequate to address HIV/AIDS issues in a culturally bound community such as the Borana pastoralists. In a collectivist culture like Borana, individuals' logical decision-making regarding high-risk behaviour is influenced by different socio-cultural and demographic factors. In addition, in male-dominated cultural societies, sexual matters are usually determined by men. Women are dependent on men, although they are aware of the seriousness of HIV/AIDS. In such communities, women are unable to determine HIV/AIDS preventative measures (Ramjee & Daniels 2013).

To address HIV/AIDS among the Borana community, knowledge of HIV/AIDS alone is not enough.

The communication should consider the role of other factors such as gender to prevent HIV/AIDS. Female education, empowerment, and social change can help to reduce the risks of HIV/AIDS. Nevertheless, in a community that considers women as a resource given to the husband and/or clans, the campaign strategy should consider the existing situations beyond the knowledge aspect of the disease. In general, the health belief model undermines the influence of local factors like friends, families, and social norms to prevent diseases like HIV/AIDS. This model overlooks the cultural context to communicate health issues. In addition, it undermines the role of a collectivist culture in health development and disease prevention. Therefore, this model is not adequate to combat HIV/AIDS problems in the culturally bound pastoral community in Borana (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa 2007).

3.3.2 The theory of reasoned action

The theory of reasoned action suggests that a person's health behaviour is determined by their intention to perform a certain behaviour (Choi & Suh 2022). A person's intention to perform behaviour (behavioural intention) is predicted by a person's attitude towards the behaviour and subjective norms regarding the behaviour. Subjective norms are the result of social and environmental surroundings and a person's perceived control over the behaviour. According to this theory, a positive attitude and positive subjective norms result in greater perceived control and increase the likelihood of intentions governing changes in behaviour (Pourgholamamiji et al 2023). This theory is based on one-way communication and asserts that a given behaviour is determined by an individual's intention. The theory of reasoned action overlooks the influence of the collective culture on individual's behavioural intention. It also assumes that individuals are rational in their decision-making process.

In a country like Ethiopia, where an individual's health decisions are influenced by a collectivist cultural group, this theory is not adequate to tackle the problems of HIV/AIDS. The theory of reasoned action can predict and explain the reason why people are not engaged in certain behaviour (Pourgholamamiji et al 2023). This implies performance of a given behaviour is based on the strength of the person's intention to perform that behaviour. In addition, the theory believes a person's attitude determines performance of a given health behaviour (Fishbein & Yzer 2003:165). According to the theory of reasoned action, performing a given behaviour is based on an individual's willingness to do it, or not to do it (Jadgal et al 2023). The theory assumes people have acquired the opportunities and resources to be successful in performing the desired behaviour, regardless of the intention.

The theory also gives focus to individual level health intention. However, this cannot be true in the collectivist culture where individual behaviour is influenced by local factors such as culture. In a collectivist culture such as the Borana pastoralist community, people think in a collective way. An individual performance of a given behaviour, whether harmful or helpful, is determined by the cultural group. This means decision-making in the Borana cultural context is not limited to an individual level. Individual health beliefs, attitudes, knowledge, and practices are affected by the cultural group. The networking at interpersonal, community, and societal levels can highly influence one's health behaviour.

The theory of reasoned action cannot be effective to address HIV/AIDS messages among Borana pastoralists. It overlooked the role of culture in determining individuals' behaviours. Motivation and constructs at individual level are given emphasis over collective decisions. External factors like gender inequality, illiteracy, power imbalance, and cultural factors that influence individuals' health decisions are overlooked in the theory of reasoned action (Jadgal et al 2023). For instance, in Borana, a woman's sexual interest is influenced by men. The Borana community should be studied and assessed in terms of the local situations. The preventive measures given and facilitated, based on the unique needs and context of the target community, need to address HIV/AIDS issues (Gelibo et al 2022). The theory cannot adequately address HIV/AIDS issues among the Borana pastoralist community because the theory overlooks the influence of collectivist culture on the individual's health decisions. Diffusion of innovation theory is discussed in the next section.

3.3.3 Diffusion innovation theory

Diffusion of innovation refers to the process that occurs as people adopt, for example, a new idea, product, practice, or philosophy (Kaminski 2011). Rogers mapped out this process, stressing that in most cases, an initial few people are open to the new idea and adopt its use (Kaminski 2011:19). As these early innovators "spread the word", more and more people become open to the new ideas which lead to the development of a critical mass. Over time, the innovative idea or product becomes diffused among the population until a saturation point is achieved (Kaminski 2011).

Diffusion of innovation theory has been extensively applied in public health to examine the process by which innovation is communicated to individuals and groups. It builds on a staged model of awareness, persuasion, decision, implementation, and confirmation; it categorises communities according to innovation (Iqbal & Zahidie 2022:533).

The theory focuses on the communication process through which a new idea or product becomes known and used by people in each population. There are relevant principles of this theory widely used in AIDS campaigns. The theory is crucial in creating awareness of HIV. Diffusion of innovation illustrates the spread of an idea in a society over time (Bhattacharya et al 2020:3).Through this theory the behavioural changes are delineated from what people used to do earlier. The main concern is that people should accept and realise that the innovative idea is beneficial to them. The greater the perception of the benefits of the idea, the more expeditious the diffusion (Bhattacharya et al 2020:3). In addition, this theory believes that using opinion leaders to influence attitudes and behaviours is vital in health communication. “Diffusion of innovation theory has been criticised for being too linear, for having a pro-innovation bias, and for widening the gap between the ‘information haves and have-nots’ in a social system”. Despite its limitations, the use of opinion leaders in helping to shape culturally appropriate strategies is acceptable.

In addition, the theory believes in relationships and negotiation in families and communities, which is relevant to this study. Moreover, the diffusion innovation theory claims that the language of communication will be a factor in the outcome of HIV/AIDS prevention and care, which this study believes to be essential. However, the innovation theory fails to account for the influence of societal, cultural, and extraneous factors affecting individual behaviour change (Iqbal & Zahidie 2022:533). The theory did not pay attention to the collective cultural practices and interactions among the different levels. It focused on changing individual behaviour through linear communication. This is not accepted in the collectivist and culturally bound Borana pastoral community. Moreover, the theory assumes all people are logical thinkers and good decision makers of their health. Therefore, this theory is less applicable in the culturally bound pastoral community of Borana.

3.3.4 The social learning/cognitive theory

The social learning theory recognises that individual behaviour change is due to interactions among cognition, behaviour, the environment, and physiology. Bandura (1986) argues that there are two main domains used in HIV/AIDS programmes. These are “modelling (imitation of the behaviour) and self-efficacy (perceived ability to adopt a recommended behaviour)”. This theory believes that “people need to be given both a reason to alter risky habits and behavioural means, as well as the resources and social support to bring about changes” (Bandura 1994:25). The social cognitive theory emphasises the psycho-social dynamics influencing health behaviour and methods to promote behaviour change.

This theory assumes that individuals have the "capacity to symbolise behaviour, to learn by observing others, to have confidence in performing behaviour, to self-determine or self-regulate behaviour, and to reflect on and analyse experience" (Baranowski, Perry & Parcel 2002:165). Components like modelling, peer education, or peer involvement are considered important in disease prevention (Peer Educators National Conference 2006). In social cognitive theory, the environment and individual are major aspects in behavioural dynamics. The interaction of the two aspects leads to behaviour, which is referred to as reciprocal determinism. The term "environment" in reciprocal determinism is used to refer to external factors that can affect a person's behaviour. The social environment includes family members, friends, and peers. The physical environment may include the size of the room, temperature, or the availability of certain foods (Baranowski, Perry & Parcel 2002:168). According to this theory, to prevent HIV/AIDS individuals are required to exercise influence over their own behaviour and their social environment. The assumption is that if people have adequate information about HIV/AIDS, they can take appropriate self-protective action. However, this might not always bring heightened awareness and knowledge concerning HIV/AIDS (Fishbein & Guinan 1996:5). There is a difference between accessing information and using it for behavioural change (Bandura 1994:25). Successfully changing one's behaviour requires strong self-belief in one's efficacy. People's self-belief about their capabilities affects their health decisions (Bandura 1994:25). The major focus of the social cognitive theory is to equip people with the necessary skills and self-belief. The theory assumes that exercising self-power can help people to protect themselves from health problems, including HIV/AIDS (Bandura 1994:26). Thus, the argument of the social learning theory is applicable and functional in the individualistic western culture. However, the question remains about its relevance in cultures where an individuals' health decision is the result of group norms. In a collectivist culture like the Borana pastoral population, focusing on HIV/AIDS knowledge and information alone cannot bring positive change. The theory, in its modelling approach, intends to educate people about HIV/AIDS through approaching an individual behaviour. This approach is based on the western philosophy of health promotion (Gelibo et al 2022; Mabweazara, Ley, & Leach 2018; Airhihenbuwa 2000). According to Whitham, Sterling, & Wood (2013), social learning theory neglects differences in the community. The theory shows little interest in individual differences relating to biological and cultural factors. Social learning theorists have failed to provide a concise idea of how the various learned behaviours are integrated to form the total personality (Whitham, Sterling & Wood 2013). In the context of the Borana pastoralist community, where the people are guided by cultural principles, norms, and values system, applying this theory is not adequate.

The cognitive behavioural theory emphasises the individual as a rational actor in altering behaviour. However, group norms, collective change, and participation are essential to change behaviour (Morris 2003:226). The social cognitive theory advances the skill enhancement approach to HIV/AIDS, which focuses on individual-based strategies of behavioural change that are acceptable in the western cultures. The potential of the theory to explain complex health behaviour and direct interventions among the communal and culturally bound Borana pastoralist community is limited. As a result, the social learning theory is not adequate to explain HIV/AIDS communication among Borana pastoralists. Hence, there is a need to integrate the theory with the contextual domains in the local community for effective behavioural change. The next section discusses the social marketing theory.

3.3.5 The social marketing theory

Social marketing is used as an intervention strategy in global health. It uses marketing concepts—product design, appropriate pricing, sales and distribution, and communication—to influence behaviours that benefit individuals and communities (Firestone et al 2017:110). Social marketing interventions generally aim to ensure that the target audience adopts the behaviour being promoted. As a behavioural theory, it focuses on disease prevention mechanisms such as condom promotion (Octavia 2018). The theory is an organised approach to promoting acceptability of a social idea (Guttman 1997). Social marketing is about product, place, and promotion. Its application started in the early 1980s. Social marketing is the design, implementation, and oversight of programmes that seek to improve the attitude of received ideas, reason, and social practices in the target group. Basically, it is the application of a commercial marketing strategy to “sell” the idea to change a society, especially in its management, including analysis, planning, implementation and control (Hermawan 2006). For public organisations, social marketing plays an important role in conveying the message to the society. One of the roles of government is to provide the public services needed by a society. It must ensure that the public service provided can satisfy the community (Octavia 2018).

The idea of social marketing is important to promote services and products like condoms to prevent the spread of HIV/AIDS. However, the social marketing theory overlooks the use of the contextual domain in the target areas (Octavia 2018). The role of social marketers is to capitalise on consumers’ immediate environment to persuade them to use the service or product, regardless of the influencing factors such as social, cultural, and economic factors

(Haider, Shannon & Moschis 2022). In addition, it has ethical problems. This means the theory sometimes utilises manipulation such as fear, to promote condom use. Furthermore, it uses a simple solution like condom distribution to a complex problem without addressing the social conditions that may fuel the spread of HIV/AIDS. Condom promotion by itself is not enough in Borana where sexuality is a taboo topic. Furthermore, social marketing focuses on individuals' behavioural change, which overlooks the collectivist culture. The idea of social marketing should integrate the essence of socio-cultural aspects, which considers both medical and social issues in health promotion. Promoters of social marketing agree on the goal of achieving behaviour change in target populations. However, critics of social marketing have argued that behaviour change is difficult to achieve solely through the mechanisms adopted by social marketing (Firestone et al 2017:120). Even if social marketing may encourage people to buy products and services, it is not clear whether this behaviour change can be sustained. Definitions of social marketing have expanded in response to critiques that social marketing can be effective only if the approach operates within an enabling policy and social environment (Firestone et al 2017:124).The social marketing theory is driven by the western values that did not focus on the values of a collectivist cultural group, like the Borana pastoralists (Haider, Shannon & Moschis 2022).Therefore, the theory is not adequate for the developing countries as it undermines the local contexts of the target population. The social marketing approach should integrate the Indigenous socio-cultural norms and values for its effectiveness.

3.3.6 The trans-theoretical model or stages of change model

The trans-theoretical model is an integrative framework for understanding how individuals and populations progress toward adopting and maintaining health behaviour change for optimal health (Prochaska, Johnson, & Lee 2009). This model is one of the behavioural models in health communication. It explains that individuals, who understand the need to change, are ready to act safely (Kaufman et al 2014). According to this model, an individual that can see the benefits of health communication are confident enough to change their behaviour (Kaufman et al 2014:250). Individuals who change their behaviour move through a series of stages of change. A pre-contemplation stage explains that people have no intention to change their behaviour overnight. The contemplation stage happens when an individual considers change. Preparation for action is the third stage where individuals plan to change their behaviour. The next stage is the action stage where individuals have changed their behaviour but have only been engaging in the new behaviour for less than six months. The final stage of change is maintenance, in which individuals have been engaging in the new

behaviour for more than six months (Bogart & Delahanty 2004). “The importance of stage theory is that it would address the major gaps in non-stage theories (for example the health belief model) which acknowledge only quantitative differences between people in their likelihood of action and position on variables” (Weinstein & Sandman 2002:5).

The trans-theoretical model, or stages theory, provides insight into the series of changes and the combination of variables in various stages of change when people engage in health behaviour. This theory increases the chance of designing more effective and efficient interventions (Weinstein & Sandman 2002). However, the trans-theoretical model is not adequate for HIV/AIDS communication among the Borana pastoralist community. The stages in this model are based on predictable behavioural change. In addition, the focus of stages theory is changing individual behaviours, which do not consider the role of contextual domains. The specific periods used to distinguish between stages are arbitrary, thus making it difficult to guarantee people’s correct assignment across stages (Weinstein, Rothman & Sutton 1998). Furthermore, a heterogeneous group of people have different health beliefs and understanding. Different people indifferent cultures and contexts require techniques that should consider these differences. The stages of change theory overlooked the contexts of the collectivist cultural group, and therefore, the stage of change theory is not adequate for this study.

3.3.7 The Multiple Domain Model

Attempts to slow down the HIV epidemic worldwide have led to a clearer understanding that the battle is not simply about using condoms or adherence to medication (Kaufman et al 2014). This implies that HIV risks and AIDS care involve complex behaviours influenced by multiple levels: from an individual’s knowledge, attitudes, emotions, and risk perception, to power dynamics between partners, accessibility of services, economic inequalities, criminalisation of vulnerable groups, and policies that make HIV a priority health issue (Kaufman et al 2014).The multiple domain model states that situational/contextual variables are the most proximal to human behaviour (Zimmerman, Christakis & Meltzoff 2007). “The multiple domain models start with the theory of planned behaviour, replacing perceived behavioural control with self-efficacy. It then adds structural factors in the sociological sense (race, gender, age, social class) and variables that address personality, the social environment (family relationships), and social situational variables (substance use, relationship status, or hormonal contraceptive use)” (Zimmerman, Christakis & Meltzoff 2007:364).

This model asserts that socio-structural, socio-environmental, and situational/contextual factors could potentially influence behaviour directly (Zimmerman, Christakis & Meltzoff 2007). It considers the influence of the contextual domains in changing behaviour. It further explains that health communication should consider contexts away from the individual, like the socio-structural, socio-environmental, and situational/contextual to influence behaviour. The present study shares the idea of the model. This is because this study is interested in the socio-cultural contexts, which are external to a social group and should be considered for effective HIV/AIDS communication. However, the model has its drawbacks when applied as is. It is driven from the individual behavioural change approach. In a collectivist culture such as the Borana pastoral community, individual behaviour is influenced and shaped by the social group or community. Airhihenbuwa (2000) stated that the model overlooks the nature of strategies to be used in health communication. Like other behavioural models, this model considers an individual as a rational thinker that will accept health messages. The behavioural dynamics is not considered in the model; the model assumes the external contexts as fixed resources. The model is essential because it emphasises the importance of factors outside the target group for health behavioural change. However, the model is not sufficient in the context of the culturally bound Borana pastoralist community. The model is driven from the individualistic point of view, which overlooks the situations in the collectivist cultural group. The next topic presents cultural frameworks in the context of this thesis (Airhihenbuwa 2000).

3.3.8 The PEN-3 cultural model

Theories about health behaviour are commonly used in public health and often frame problems as ascribed or related to individual actions or inaction. This framing suggests that poor health occurs because individuals are unable or unwilling to heed preventive messages or recommended treatment actions (Dadipoor et al 2023; Iwelunmor, Newsome, & Airhihenbuwa 2014:26). Culture has become crucial to implement effective public health interventions (Airhihenbuwa & Liburd 2006). Increasing focus requires a clear understanding of the impact of culture on health. Culture refers to shared values, norms, and codes that collectively shape a group's beliefs, attitudes, and behaviour through the interactions with their environments. Exploring the cultural contexts of a social group allows one to understand and appreciate the ways in which the individual cultural elements influence health messages. Cultural beliefs are considered a determinant for understanding health risks and health-promoting behaviours in different populations (Kim et al 2019). For public health message effectiveness and sustainability, understanding the cultural dynamics of the

target population is indispensable (Dadipoor et al 2023; Kim et al 2019; Iwelunmor, Newsome & Airhihenbuwa 2014).

The PEN-3 model was originally developed by Airhihenbuwa in 1989 (Airhihenbuwa & Webster 2004) to guide the development of culturally competent HIV-prevention programmes in Africa. The premise is that culture is the foundation of health promotion, and it has been used to assess an array of health behaviours, such as understanding attitudes and health behaviours relating to HIV/AIDS transmission among Africans. The cultural model is based on the influence of culture on health. The model is helpful to create an understanding of the role that culture plays in the development of societal health. The PEN-3 model is suitable for health education in developing countries as it addresses cultural sensitivity in programme development (Airhihenbuwa 2007a). The assumption behind the PEN-3 cultural model is that there will be poor health outcomes if the cultural norms and value system of the specific social group is overlooked in the process. This means culture should be central in the study of health beliefs, behaviours, and health outcomes (Airhihenbuwa 2007). Individuals' perceptions and actions regarding health are shaped and defined by their cultural beliefs and practices (Airhihenbuwa 2007).

The PEN-3 cultural model is recommended for Africa to promote societal health (Cowdery, Parker & Thompson 2010:26). The model provides valuable guidelines to ensure that the health intervention is culturally specific. For this, health and HIV/AIDS programmes should use the community's cultural components for effective behavioural change. A disease prevention strategy needs to consider the inclusion of the socio-cultural context of the specific social group. There are three main domains of the PEN-3 cultural model (Iwelunmor, Newsome &Airhihenbuwa 2014:20). These domains are cultural identity, relationships and expectations, and cultural empowerment. "Each of these domains consists of three factors that form the acronym PEN: Person, Extended Family, Neighbourhoods (cultural identity domain); Perceptions, Enablers, and Nurturers (relationship and expectation domain); Positive, Existential and Negative (cultural empowerment domain)" (Airhihenbuwa 2007, 2007).

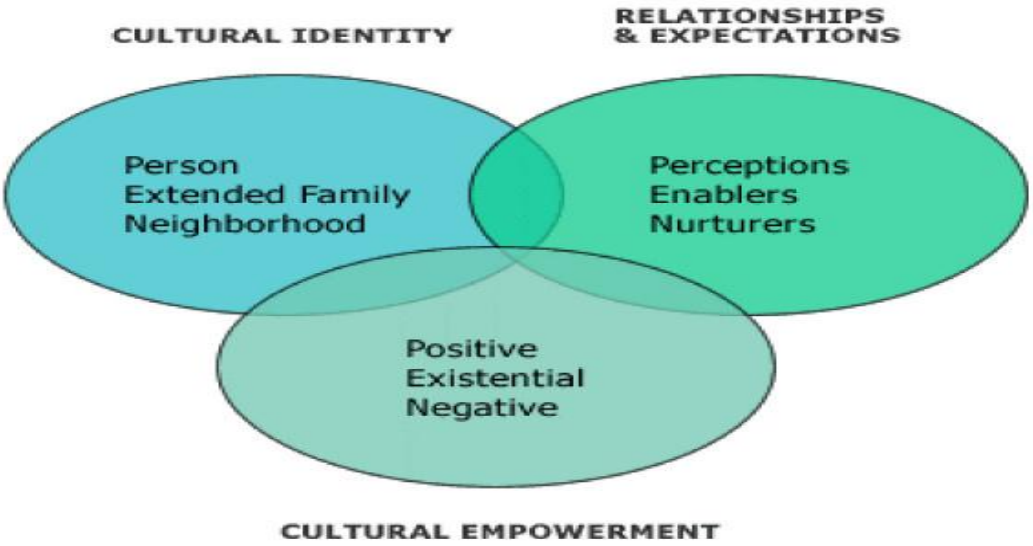


Figure3.1: The PEN-3 cultural model

Source: Olufowote 2021; Iwelunmor, Newsome &Airhihenbuwa 2014:26

The primary domains: cultural identity, relationships and expectations, and cultural empowerment, address important concepts that need to be considered in public health promotion programmes. These concepts are important as they explain the centrality of culture to bring about social behavioural change.

3.3.8.1 Cultural identity domain

The cultural identity domain highlights the intervention points of entry where health interventions start. These may occur at the level of persons (e.g., mothers or healthcare workers), extended family members (grandmothers), or neighbourhoods (communities or villages) (Olufowote 2021; Iwelunmor, Newsome & Airhihenbuwa 2014:20). The main concern of this domain is that issues related to an individual, extended family, and neighbourhood should be considered to address health issues including HIV/AIDS. The concern of this domain as it pertains to health education is that health education should be committed to promoting health and preventing disease at individual, neighbourhood, and community levels. HIV/AIDS communication should consider issues beyond the individual level. Although the individual is important in HIV/AIDS communication, the role of family and neighbourhoods are crucial as individual identity is shaped by family members and neighbourhoods in the collectivist Borana culture.

3.3.8.2 Relationships and expectations domain

According to the relationships and expectations domain, perceptions (or attitudes) about the health problems and the societal (or structural) resources such as healthcare services that promote or discourage effective health seeking practices, are essential. The influence of family and kin in nurturing decisions surrounding effective management of health problems are examined (Olufowote 2021; Iwelunmor, Newsome & Airhihenbuwa 2014:20). The domain also connotes that knowledge, attitudes, values, and perceptions that may facilitate or hinder personal motivation to change should be considered while addressing health problems. Furthermore, this dimension of disease prevention considers structural as well social factors such as resources, health facilities, peer pressure, and employer situations that influence health service provisions. HIV/AIDS communication among Borana pastoralists should consider the structural, social, and relationships factors that influence health behaviour.

3.3.8.3 Cultural empowerment domain

The cultural empowerment domain explains that “health problems are explored first by identifying beliefs and practices that are positive, exploring and highlighting values and beliefs that are existential and have no harmful health consequences, before identifying negative health practices that serve as barriers” (Olufowote 2021; Iwelunmor, Newsome & Airhihenbuwa 2014:21). The cultural empowerment or cultural appropriateness dimension is important for developing the culturally sensitive health education programmes of developing countries.

The third dimension, cultural empowerment, connotes the following aspects: “P (positive behaviour), behaviours that is known to be beneficial and should be encouraged. The E (exotic behaviour), unfamiliar behaviours that has no harmful health consequences and therefore need not be changed, and (negative behaviour), that are harmful to health and which health providers should attempt to help people change” (Cowdery, Parker & Thompson 2010:2). Positive cultural resources that encourage HIV/AIDS communication should be identified and properly utilised for HIV/AIDS communication. Then, unfamiliar behaviour which has no effect on health communication should be wisely managed. Lastly, harmful practices and cultural resources that negatively affect the health of the Borana

pastoralist community should be effectively communicated and handled. Managing such harmful cultural practices is possible through a participatory approach. The community should first accept that the harmful practices have negative consequences to the development of their own health.

In the past, most attention was paid to the negative aspects of cultural practices (Olufowote 2021; Iwelunmor, Newsome & Airhihenbuwa 2014:27). Culture should be supporter and should not be singled out as the explanation for the failure of a health intervention. Concerning HIV/AIDS, culture can also be viewed in terms of its strengths and attributes that are helpful in HIV/AIDS prevention, care, and support (Iwelunmor, Newsome & Airhihenbuwa 2014:27). Communities should be involved in health IEC programmes using their cultural resources. Health programme planners need to consider individual and community needs — the effectiveness of health programmes from the contexts of the audience. All health programmes, including HIV/AIDS programmes, should consider the cultural components, evaluate the effectiveness of these programmes, and ensure that each phase addresses the local contexts. Health programmes, such as HIV/AIDS programmes, among Borana pastoralists should be planned with the community, for the community. Airhihenbuwa (2007b, 1995) stated that the PEN-3 cultural model recognises the cultural diversity among populations. Health programmes that are relevant to the socio-cultural contexts of a given community may not work for others. The impact of culture in the health system is realised when there is community participation. Community participation is realised when individuals, families, and communities for whom a programme is intended are part of the health problems as well as the solution. This community empowerment to develop health ensures the importance of cultural sensitivity to address health problems. In addition, community involvement in health programmes gives focus to the role of traditions, values, customs, and social norms in health promotion. Involving the community in their health matters also helps to evaluate whether a given disease prevention strategy is culturally appropriate or not.

Understanding cultural sensitivity is crucial for the Borana pastoralist community in Borana, Ethiopia to communicate health messages. The idea of cultural sensitivity is also acceptable in the context of Ethiopia, a multi-lingual and multi-cultural country. More than 80 ethnic groups in Ethiopia have their own language and cultural values. To address health problems in an Ethiopian context, it is crucial to understand the cultural variations in the communities. Iwelunmor, Newsome & Airhihenbuwa (2014) also pointed out that the PEN-3 cultural model, as a transition from the behavioural models to the cultural model, can play a significant role

in HIV/AIDS prevention strategies. Therefore, the idea and philosophical underpinnings of the PEN-3 cultural models can be adopted for this study. The next section elaborates on the use of a contextualised HIV/AIDS communication framework in the context of Africa.

3.4 UNAIDS COMMUNICATION FRAMEWORK FOR HIV/AIDS

Significant difference is observed among the world population concerning public health promotion (Hovland et al 2021). These differences would force different countries to adopt their own health communication strategies that suit their own country's context (Iwelunmor, Newsome & Airhihenbuwa2014:1).The study by Bunn et al (2020) and Amzatand (2018) confirmed that the use of communication strategies that reflect the target group's social and cultural reality, as well as using tools or devices that appear to be relevant and appealing to the target group, can promote the target group's receptivity to the message. The UNAIDS communication framework was initiated to address the specific health communication needs of the developing countries. This communication framework was recommended for the culturally bound developing countries on the continent of Africa (UNAIDS 2001). The assertion of the framework is that health communication is a planned intervention that should combine the contextual domains like culture, gender, spirituality, socio-economic status, government law/policy, and community approaches.

The UNAIDS communication framework is recommended to communicate HIV/AIDS issues (Airhihenbuwa & Obregon 2000:327).The central concept of the UNAIDS communication framework of communication is that health communication, such as HIV/AIDS campaigns, should not overlook the communication dynamics and cultural values of the group. Overlooking such socio-cultural components creates serious communication gaps and yield erroneous results (Airhihenbuwa 2007a; Dutta 2007). Therefore, this communication framework is chosen to guide this study. The next topic presents the rationale to use the UNAIDS framework of communication.

3.4.1 The foundation for the UNAIDS communication framework

The UNAIDS communication framework is founded on the contextual domains of the target society (Airhihenbuwa 2010). The framework asserts that socio-cultural domains are the hub to ensure societal health. It further addresses the matter that assuming culture as a peripheral component (or irrelevant to health), cannot address the intended messages.

Understanding the holistic context including norms, values, belief systems, religion and spirituality, language, and the totality of life of the target community would help to tailor HIV/AIDS communication to the contexts of the community (Michal & Bowen 1992:167).

Buseh, Glass and McElmurry (2002:174) indicated that Africa is rich in traditions and cultural values. Designing African health promotion programmes requires an understanding of these cultural realities. Health delivery in a community could be influenced by the cultural practices, belief system, knowledge and attitude, as well as extraneous variables of socio-cultural elements of the cultural group (Foster et al 1993). “The success of any health promotion campaigns in a community relates to how much consideration is given to the unique cultural resources” (Livingston 1992:767). The health communication planning therefore needs to consider the community-based cultural values, traditions, beliefs, and customs (Scott, Gilliam & Braxton 2005:19).

Many HIV/AIDS preventive programmes advocate for the use of condoms and safe sexual practices (Kalichman & Kelly 1995:907). However, such caution failed to consider the socio-cultural aspects that encourages people to practise unsafe sex. In addition, the caution did not consider the nature of extramarital sexual intercourse that is part of cultural practices in developing countries. Socio-cultural factors affect women’s sexual behaviour in Africa (Kalichman & Kelly 1995:907). This shows that sexual behaviour should be explored in line with the cultural contexts of the specific social group. This study intends to adopt the UNAIDS framework of communication since it is based on culture to design HIV/AIDS prevention and communication strategies.

In addition, the UNAIDS communication framework reveals that HIV/AIDS communication strategies should address the specific communication needs of the target population (UNAIDS 1999c:83). Furthermore, the framework recognises the variations among regions and communities so that HIV/AIDS communication should be coined accordingly. The house-to-home metaphor of the UNAIDS communication framework indicates, “Every house has a foundation, roof, and the body designed to respond to the conditions in the environment or context.” Transferred to HIV/AIDS communication, this implies that to address HIV/AIDS problems, it is essential to consider the micro contexts like culture, gender, spirituality, and community level contexts. The UNAIDS communication framework was adapted to guide this study. This is because the identified domains like culture, religion/spirituality, gender, and communication are in line with the PEN-3 cultural model, which focuses on the socio-cultural approach to health communication.

The components of the framework are among the undervalued areas but play a pivotal role in the campaigns against HIV/AIDS in Africa. The selected domains are also related to the Indigenous contexts of the target pastoralist community in Borana, Ethiopia.

In general, the socio-cultural domains are linked to the objectives of this study. The major domains of the UNAIDS communication framework adapted for this study are presented in the following section. HIV/AIDS communication in Africa focused on large-scale information dissemination (UNAIDS 1999c). Large-scale information dissemination intended to bring behavioural change in the larger community in a short period of time. However, the HIV/AIDS epidemic continued regardless of these efforts for more than three decades. A communication framework that is culturally driven is crucial to curb the spread of HIV/AIDS in Africa (UNAIDS 1999c). Community-based communication approaches that consider the context in the local domain are important for effective HIV/AIDS communication in Africa. The underpinning reality of a community-based HIV/AIDS communication approach is that HIV/AIDS communication should engage the target community. This is important to tackle the community-based traditional practices that fuel the spread of HIV/AIDS, as community based traditional practices continued regardless of the HIV/AIDS IEC (UNAIDS 1999c). Traditional practices that aggravate the spread of HIV/AIDS require the community to take accountability for their own health.

Sustainability of the HIV/AIDS programme will not be guaranteed unless the target community owns the prevention strategies. HIV/AIDS communication in Africa focused on large-scale information dissemination. The community-based approach, as an important domain of the African HIV/AIDS communication framework, is essential in the context of this study. This can be applied to the Borana pastoralist community where HIV/AIDS communication approaches did not adequately engage the community so far. The pastoral community should own HIV/AIDS campaign programmes using the socio-cultural resources to control the spread of the epidemic. Investigating the socio-cultural appropriateness of HIV/AIDS communication approaches to the context of the Borana pastoralists is the focus of this study. The next topic presents some of the underpinning realities that forced Africa to look for a new communication framework.

3.5 WHY A SHIFT IN BEHAVIOURAL THEORIES OF HEALTH COMMUNICATION?

Health behavioural theories and models have been criticised for overlooking the contextual domains in the developing countries like Ethiopia (Dadipoor et al 2023; Moghaddam,

Shahnazi & Hassanzadeh 2019; Iwelunmor, Newsome & Airhihenbuwa 2014; Scarinci et al 2012). As a result, there are varied reasons that necessitated a shift. The behavioural theories and models assumed that all individuals are rational thinkers and can make decisions concerning their health behaviour. This means individuals can accept HIV/AIDS messages and bringing behavioural change. However, this does not work for the Borana pastoralist community where an individual's health decision is influenced by the cultural group (Airhihenbuwa & Obregon 2000:10-15). In addition, individuals in developing countries such as the Borana pastoralist community cannot make health choices because of the community's influence. For example, the sexual right of women in developing countries like Borana is influenced by their husbands. Western behavioural theories and models encourage one-way and persuasive communication. The theoretical models that are used to guide the intervention perspective provide a prefabricated and bounded way of thinking. The behavioural theories and models lack situational sensitivity and cultural grounding, and therefore cannot be applied to the culturally bound Borana pastoralist community. (Lie 2008:14-15). HIV/AIDS prevention programmes should consider the cultural realities in the local community. The behavioural models oversimplify complex situations (Lie 2008:14).

The socio-cultural behaviours should be considered in addressing health messages (Mabweazara, Ley & Leach 2018:203).Individual lifestyles, the working environment, and cultural determinants are intertwined and influence each other resulting in increased risk behaviour and more complex structural barriers for testing and treatment among key populations (Khandu, Tobgay & McFarland 2021).This shows that HIV/AIDS programme planners need a greater understanding of context of the target audiences. The community's health communication should be viewed in correlation with the target Borana population. It should be known that health decisions in the developing countries are not only determined by an individual's health knowledge. The health decision could also be influenced by factors like economic problems and gender inequality (Davis et al 2015:323). For instance, in economically disadvantaged and culturally bound Borana, having the knowledge of HIV/AIDS alone cannot prevent the spread of the epidemic. The western behavioural models should therefore consider such socio-cultural contexts in the Borana pastoralist community.

HIV/AIDS interventions should address the larger contextual issues that characterise the population groups, such as women, in developing countries (Mabweazara, Ley & Leach 2018). Most behavioural theories and models such as the health belief model, the theory of reasoned action, social learning, diffusion innovation theory, and social marketing theory, indicate that HIV/AIDS campaign strategies do not emphasise culture as a central concept.

These psychological models have been used but they fail to consider the social contextual issues of gender, class, and ethnicity (Khandu, Tobgay & McFarland 2021). In addition, most behavioural theories are not native to the socio-cultural contexts of non-western countries (Moola 2010:43). This implies the western-originated health behavioural theories and models are based more on the individualistic culture whereas most non-western countries, including the Borana pastoralist community in Borana, have a communal society and are well known for their collectivist culture. Another important reason for the shift is that theories based on the individual behaviour, which may be effective and meaningful in a western context, have lesser relevance in the self-efficiency cultures of Asia, Africa, Latin America, and the Caribbean. In these regions, family and the community are more central to the construction of health and well-being than the individual, even though the individual is always recognised as an important part of the cultural context (Moola 2010). Furthermore, western behavioural theories are more focused on rationally thinking individuals to prevent health problems. Mass media is also the medium of communication that is focused on. This approach is not adequate in the traditional oral culture in Africa such as the Borana pastoralist community. This means disease prevention, including HIV/AIDS prevention, in Ethiopia should integrate the socio-cultural contexts of the local community (Gelibo et al 2022).

Language and culture play a role in clients' understanding of health information (Bastien, Kajula, & Muhwezi 2011). Medication adherence and disease understanding increase when patients receive information regarding their treatment plan that is tailored to their specific need (Khandu, Tobgay & McFarland 2021). African communities are known by their oral culture. The spoken word is given priority among the oral culture (Bastien, Kajula & Muhwezi 2011). The power of the spoken word has always been recognised by Africans as the hallmark of the varied interpretations and the value of storytelling; interpretations may also sometimes be encoded in songs of a story (Airhihenbuwa, Ford &Iwelunmor 2014). It is essential to consider the social reality in health promotion. This also works for the oral-dominated Borana culture. Besides, Airhihenbuwa (1995) explains that the language of a community signifies culture. Language needs to represent the oral culture of the community for effective communication.

In regions such as the Borana pastoral community where illiteracy levels are high and mass media exposure is low, depending on mass communication may not be effective. It is crucial to focus on the traditional ways of communication, such as folk media (Panford et al 2001:1560).

The idea to perform or not to perform a given behaviour should be assessed primarily from the perspective of the Indigenous contexts (Panford et al 2001:1560). The behavioural theories and models of communication should consider the literacy level in the developing countries. The theories and models should be embedded within the culture of the specific community.

Health promotion programmes that are culturally appropriate are effective. Health beliefs, actions, and practices should be examined within the context of a culture of a given community (Airhihenbuwa 1995:26). “People normally identify with sources that are trustworthy, credible, and similar to them in terms of age, race, sex, ethnicity, socio-economic status, employment, educational level, marital status, family structure, and place of residence or other demographic type of variables” (Kreuter & McClure 2004:443). HIV/AIDS promotional materials should be designed in such a way that the approach is familiar to the target people.

Health communication in the context of developing countries should follow a socio-cultural path. The communication approaches and materials need to consider the cultural sensitivity in the specific group. “Cultural sensitivity is the extent to which ethnic/cultural characteristics, experiences, norms, and behavioural patterns are incorporated to design, deliver, and evaluate health promotional materials and programmes” (Resnicow et al 2002:10). There is a need for culturally sensitive health programmes because of the diverse and changing demographics of communities, as well as the need to incorporate ethnic-specific determinants of behaviour of targeted health promotion programmes. The Institute of Medicine (2002:242) acknowledges the fact that communication strategies and decision-making are influenced by cultural patterns. Health messages are also influenced by personal interests, socio-cultural values, situations in which communication occurs, ways of communication, audiences’ experience regarding the content of communication, and message clarity regarding audiences’ realities.

Health promotion and health communication programmes should be supported by culturally suitable approaches. For instance, peripheral, evidential, linguistic, and socio-culture approaches can be considered in health promotion. A peripheral approach would make the target audiences comfortable and familiar with health messages. Evidential approaches assist in showing the impact of a health condition to a specific audience (Kreuter & McClure 2004:446). A linguistic approach makes health communication campaigns, programmes, and materials accessible using the native language of the target people (Kreuter & McClure

2004:447). Socio-cultural approaches recommend that health messages should be presented and find meaning within the social or cultural setting (Kreuter & McClure 2004:446). Socio-cultural contexts are at the centre of all the different health communication approaches. HIV/AIDS communication approaches in Borana should consider the culture, language, gender, norms, and value systems of the local community.

The shift in thinking about health communication recognises the epidemiological approaches to disease prevention in developing countries (Airhihenbuwa, Ford &Iwelunmor 2014). It further recognises the importance of cultural situations for effective health promotion. Health programme planners in the developing countries have no method of evaluating the effects of their programmes from the cultural perspectives, yet (Khandu, Tobgay & McFarland 2021). This means disease preventive approaches that are not culturally sensitive or culturally appropriate will be ineffective. This is because the culturally ineffective health messages will not reach the intended audience, will not be understood by those who are reached, and will not be accepted by those who understand (Khandu, Tobgay & McFarland 2021). Beliefs and knowledge systems of the local communities should be central to health programme planning and communication strategies. For successful HIV/AIDS prevention, health workers need to understand the unique cultural factors in local areas. Cultural variables are salient in understanding the HIV/AIDS epidemic. Recognising the role of culture helps to support the campaigns against the disease (Kreuter & McClure 2004:450). The Borana pastoralist community requires culture-friendly HIV/AIDS communication that considers the nature of the pastoralist lives and contexts. The next section concludes the PEN-3 cultural model.

3.6 CONCLUSION

This chapter affirms that HIV/AIDS communication programmes in developing countries within Africa focused on the western behavioural theories and models of communication. Western-oriented models and theories, however, are not adequate to address health problems in Africa (Airhihenbuwa, Ford & Iwelunmor 2014; Airhihenbuwa et al 2009). These theories and models are based on the western values, norms, beliefs, culture, and world views which might contradict with African realities. Culture has become a key component in public health intervention strategies in Africa. Effective health communication, including HIV/AIDS communication, requires recognition of both the individual and the cultural norms in the community. The PEN-3 cultural model is critical in developing and implementing health interventions anchored in culture.

Families, extended families, nurture factors, community, and socio-cultural environments must be considered in health programme objectives. As a result, the PEN-3 cultural model is an appropriate model that can effectively guides HIV/AIDS campaigns in Africa. Engaging culture may be a dimension of participatory approaches that genuinely begin where people are, and work with them to address aspects of their lives that they identify as important (Okechi 2018). Such an engagement, however, will often be about creating the space for people to reflect on their situation and find pathways of change which work in context, rather than the promulgation of messages or putting in place processes of consensus-based decision-making, which may often be quite "unrepresentative" and subtly coercive (Okechi 2018). Health interventions should begin by understanding both useful and harmful practices in the specific community (Achen, Atekyereza & Rwabukwali 2021).

> *"The PEN-3 cultural model provides the opportunity to examine cultural practices that are critical to positive health behaviours, acknowledges unique practices that have a neutral impact on health, and identifies negative factors that are likely to have an adverse influence on health*" (Iwelunmor, Newsome & Airhihenbuwa 2013:28).

HIV/AIDS prevention in the developing regions of Africa has in the past been focusing on individual behaviour such as individual norms, knowledge, attitudes, and perceptions towards HIV/AIDS, safer sex, and other prevention strategies like ABC: abstinence, being faithful, and using condoms. Although these individual factors are important components for effective behavioural change, the behavioural models and theories undermined the role of culture (Airhihenbuwa 2007a, 2007b). HIV/AIDS communication should not only be about audience's perceptions, knowledge, and attitudes toward the epidemic. Communication concerning HIV/AIDS should go deeper to the underlying socio-cultural assumptions and social representations on which such perceptions, knowledge, and attitudes are based (Iwelunmor, Newsome & Airhihenbuwa 2014). "HIV/AIDS communication should consider the African worldviews that stand for unity, co-operation, and communality as opposed to western values of individualism, competition, and independence" (Iwelunmor, Newsome & Airhihenbuwa 2014).

In the Borana pastoralist community, theories and models that are used in HIV/AIDS programmes should be re-examined in relation to how adequate and relevant they are contextually (Airhihenbuwa et al 2009; Airhihenbuwa, Ford &Iwelunmore 2014; Airhihenbuwa& Obregon 2000:6). Western behavioural theories and models, although important, are not adequate in the contexts of the developing countries.

African's important viewpoints about life such as inclusivity, cooperation, the collective, harmony, co-existence, being spirit-centred, interconnectedness, and interrelated values are not adequately treated in the western behavioural theories of health programmes (Jim 2005:6). The western health theories and models focus on the western philosophies of health development. The socio-cultural factors in the specific population groups like gender, religion/spirituality, cultural norms, values, belief systems, and livelihoods that determine the success of HIV/AIDS interventions are overlooked in the western health theories and models. This necessitates the shift in health communication for a developing country like Ethiopia. Culture-sensitive communication approaches are important for the developing countries like Ethiopia to address HIV/AIDS messages effectively. Therefore, this study accepts culturally driven health models and theories like the PEN-3 cultural model, and the UNAIDS cultural communication framework that advocates for health interventions that are based on the specific contexts in the local areas. In addition, the multiple domain model, with all its constraints, that consider the structural factors in the sociological sense (race, gender, age, social class) and variables that address personality, the social environment (family relationships), and social situational variables (substance use, relationship status, or hormonal contraceptives) can contribute to HIV/AIDS prevention among the Borana pastoralist community. The UNAIDS HIV/AIDS communication framework that guides this study is discussed in the following chapter. In addition, a conceptual framework of HIV/AIDS communication developed for the Borana pastoralist community is presented.

CHAPTER 4
CONCEPTUAL FRAMEWORK

4.1 INTRODUCTION

Seminal health models, theories, and frameworks were presented in Chapter 3, Part II. The chapter highlighted that the behavioural communication models and theories used in the healthcare industry in developing countries lack context. As a result, developing countries such as Ethiopia require health models and theories in HIV/AIDS communication that recognise the contextual domains in the local communities. Models and theories used for health development need to integrate the contextual domains of the specific population. Health communication approaches should be framed in the socio-cultural context of the local population. This chapter elaborates on the conceptual framework for the study. The framework was built on the literature works that advocate the cultural lens of HIV/AIDS communication for the culturally bound developing countries such as Ethiopia.

4.2 HIV/AIDS COMMUNICATION FRAMEWORK IN THE PAST: CONTEXTS AND OBSERVABLE GAPS

Historically, western-originated models and theories of health behaviour viewed human behaviour as determined by conscious processes that involve intentional motives and beliefs (Rejeski & Fanning 2019).Accordingly, these models and theories focused on individual's behavioural change and one-way information dissemination to persuade people to bring about the desired health behaviour (Brooks, Manias & Bloomer 2019; Iwelunmor, Newsome & Airhihenbuwa 2014).Health models and theories in the past gave more focus to the epidemiological aspects of disease prevention. As a field, behavioural medicine has come to recognise that health behaviours are determined by multiple levels of influence (Short & Mollborn 2015).

An international workshop on HIV/AIDS communication in Africa held in 1997 in Abidjan, Cote d'Ivoire, indicated that HIV/AIDS communication is an area that was overlooked in Africa (Iwelunmor, Newsome & Airhihenbuwa 2014). The workshop identified that almost all African countries, with sub-Saharan Africa in the lead, have been suffering from a serious spread of the HIV/AIDS epidemic that required contextualised approach.

The UNAIDS report (2001) further pointed out that stigmatisation, persistent denial of the disease, focusing on only high-risk behaviour and poor planning for communication strategies are factors that fuel the spread of HIV/AIDS in Africa. Until then, the HIV/AIDS communication focused on the general population. The assumption was that focusing on the large-scale communication strategies would bring behavioural change (UNAIDS 2000:52). However, Airhihenbuwa et al (2009) and Dutta (2007) asserted that overlooking communication dynamics and the values of the group would create a serious communication gap and yield very little results in terms of HIV/AIDS. Africa's focus in terms of HIV/AIDS was populations with higher risk behaviour. However, the spread of the disease continued to grow not only among high-risk behaviour but also among all the other population segments, such as rural women (UNAIDS 2000:52). Iwelunmor, Newsome & Airhihenbuwa (2014) also argue that Africa needs a communication framework for HIV/AIDS that fits within the African realities. The communication models and approaches used in HIV/AIDS communication to date were not developed for the African context. Therefore, HIV/AIDS communication that would consider the socio-cultural contexts of the target African community is indispensable.

An HIV/AIDS behavioural change communication approach that is pertinent for one community, may not adequately work for another community (Achen, Atekyereza & Rwbukwali 2021). The centrality of culture is important to ensure social health. Culture is a crucial component in planning, implementing, and evaluating health communication and health promotion programmes. Different social groups may have their own unique contexts, such as socio-cultural contexts (Mabweazara, Ley & Leach 2018). This is also true in the contexts of the Borana pastoralist community. Health workers should know that context is not universal. Understanding the different contexts among social groups would aid effective HIV/AIDS communication (Klonoff 2009:49).

Empirical evidence focusing on the impact of culture on health has increased dramatically over the past few decades (Airhihenbuwa 2014; Dutta 2007). The growing impact of culture on health behaviour indicates the realisation of its importance in tackling health disparities, addressing health literacy, and designing health intervention strategies that consider the socio-cultural contexts of the target community (Thiabaud et al 2020; Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa & Liburd 2006; Shaw et al 2009). Khandu et al (2020) also indicate that shared values, norms, and codes used within the society have a pivotal role in influencing the health behaviour of the host community. Understanding the cultural contexts of the target community (positive or negative) would enable public health interventions to be effective and sustainable (Singhal & Roger 2003).

The UNAIDS communication framework advocates for the role of contextual domains to prevent the spread of HIV/AIDS in Africa (Iwelunmor, Newsome &Airhihenbuwa2013). This is because contextual domains in the community play an indispensable role in the quest to prevent HIV/AIDS in Africa. The framework also asserts that the policy environment and national economy of a country influence an individual's response to HIV/AIDS campaigns (UNAIDS 2001:8). The UNAIDS communication framework recognises that there is an inter-regional difference in the context of HIV/AIDS in Africa (Airhihenbuwa & Obregon 2000:6). However, the UNAIDS communication framework gives more focus to the macro domains such as the economy and national policy in HIV/AIDS prevention. In addition, the framework is more general and does not address the unique features of the marginalised, underprivileged, and mobile population groups such as the Borana pastoralists. The framework was developed from the contexts of few African countries and generalised to the African population which may overlook the specific contexts of each region. Additionally, the UNAIDS HIV/AIDS communication framework places more emphasis on individual behavioural change, top-down, expert-oriented HIV/AIDS IEC. The UNAIDS communication framework overlooked the role of user-friendly communication approaches in its domain. Thus, it is crucial to develop a conceptual framework of HIV/AIDS communication that suits the unique features of pastoralism and pastoral culture in Borana, Ethiopia. This study builds on the cultural approaches toward HIV/AIDS communication models, theories, and frameworks. The conceptual framework and evidence presented in the next section highlight areas across the continuum where health communication can significantly impact treatment outcomes to reach the 90-90-90 goal by strategically addressing key behavioural determinants. It justifies the need for a new conceptual framework of HIV/AIDS communication in the context of this study.

4.3 THE NEED FOR A NEW CONCEPTUAL FRAMEWORK

A theory is essentially a set of concepts, definitions, and propositions that together form a structured, comprehensive view of a specific phenomenon. A theoretical framework is a collection of existing theories, models and frameworks that provides a foundation of core knowledge – a "lay of the land", so to speak, from which the researcher can build a research study (Salawu et al 2023). Conceptual framework is an expression either narratively or graphically of the study being embarked upon. A conceptual framework is typically a visual representation (although it can also be written out) of the expected relationships and connections between various concepts, constructs or variables. In other words, a conceptual framework visualizes how the researcher views and organizes the various concepts and

variables within their study. This is typically based on aspects drawn from the theoretical framework, so there is a relationship between the two (Salawu et al 2023).

HIV/AIDS continues to be a devastating epidemic in sub-Saharan Africa. Despite extensive bio-behavioural research, individual-oriented behavioural change models and theories, HIV/AIDS remains a challenge among the culturally bound communities in Africa (Williams, Wyatt &Wingood 2010). According to Williams, Wyatt and Wingood (2010) HIV/AIDS prevention and risk reduction interventions must move beyond basic sex education and condom use and availability. It is stated that successful HIV/AIDS interventions targeting African must optimise strategies that integrate socio-cultural factors. Public health prevention comprises primary (pre-event), secondary (event) and tertiary interventions (post-event) (Uusküla et al 2020). In the context of HIV/AIDS, primary prevention reduces the incidence of transmission, whereas secondary prevention focuses on early detection and prompt ART treatment. Tertiary prevention promotes quality of life and prolongs longevity through ART, cancer treatments, and addressing opportunistic infections (Uusküla et al 2020).

The goal of health communication programmes is to increase knowledge and the understanding of health-related issues and to improve the health status of the intended audience (Brooks, Manias, & Bloomer 2019). Understanding is important to achieve this goal, especially in situations where cultural values, beliefs, and practices continue to put people at risk. According to Brooks, Manias and Bloomer (2019) in HIV/AIDS prevention, effective communication is considered an integral part of service delivery programmes to both providers and clients. For instance, in rural communities, effective communication involves more than simply disseminating health messages via popular media, or enhancing people's compliance with medical regiments (Brooks, Manias & Bloomer 2019; Uwah 2013). HIV/AIDS communication in the culturally bound community goes beyond dissemination and involves interventions that deal with issues of participation and empowerment for proper decision-making. According to Uwah (2013), health communication on HIV/AIDS in Africa cannot be effective without due emphasis on socio-cultural norms and values. It is important to note that culture does not exist independently of individuals and communities. It indicates that a socio-cultural approach to HIV/AIDS communication offers a chance to improve the effectiveness of HIV/AIDS prevention strategies and rebuild the trust of communities through more sensitive modes of engagement (Thiabaud et al 2020;Iwelunmor, Newsome, & Airhihenbuwa 2014; Uwah 2013). Local community-based HIV/AIDS communication approaches remain the most important means of influencing people.

This is because conventional public health awareness campaigns are largely unsuccessful at eliciting behaviour change where sexuality is concerned in the cultural society of Africa (Uwah 2013).

In Africa, unlike the western-originated health behavioural change models and theories, behaviour patterns are not influenced by individual decisions but are deeply embedded within the cultural norms that are inherited (Williams, Wyatt &Wingood 2010; Uwah 2013). According to Isangula and Kahabi, (2011) various characteristics contribute to determine the risk of exposure and acquisition of HIV/AIDS, and there will be causal pathways linking social, demographic, economic, cultural, behavioural, and biological variables. To address HIV/AIDS communication in the culturally bound communities of Africa, a coherent conceptual framework is needed. A culturally focused conceptual framework that can guide the development of effective health communication in HIV/AIDS communication activities that aim to bring social behavioural change is crucial.

4.4 A CONCEPTUAL FRAMEWORK OF HIV/AIDS COMMUNICATION FOR BORANA PASTORALISTS

Progress on health communication goals is critically needed in the areas of HIV/AIDS where health disparities are increasingly prevalent (Jannette et al 2009). Disparities related to HIV/AIDS services, including a communication approach, continue to be a major public health problem among the underprivileged population group (Khandu, Tobgay & McFarland 2021; WHO 2018). Adaptation of efficacious HIV/AIDS prevention interventions for use as health communication innovations is vital to increase the effective utilisation of HIV/AIDS information, education, and communication (Jannette et al 2009). Thus, careful development of a contextually appropriate conceptual framework that addresses the contexts of the target community is essential. This study considered the notion of thePEN-3 cultural model, the multiple domain model and the UNAIDS communication framework for HIV/AIDS prevention in the developing countries, such as the countries in Africa. Based on the literature, it was possible to develop a culturally driven conceptual framework of HIV/AIDS communication for the Borana pastoralist community. Firstly, socio-cultural traditions as well as Indigenous cultural institutions, such as *Gadaa* and *Gumii Gaayyoo*, are well known and acknowledged among the Borana pastoralists. Secondly, the Borana pastoralist community is rich in religious and cultural resources and traditional practices. Thirdly, the pastoral population assign roles based on gender. Ecologically, the Borana pastoralists have unique ways of life that any HIV/AIDS communication and prevention strategies should consider.

The concept of pastoralism requires a contextualised approach to HIV/AIDS communication that should consider the community's specific contexts. The above realities affirm that developing a conceptual framework of HIV/AIDS communication in the context of Borana can help to effectively combat the spread of HIV/AIDS among the collectivist cultural society. A locally relevant conceptual framework of communication would help to tailor HIV/AIDS messages to the contexts of culture, gender, religion/spirituality, and user-friendly communication. Understanding the local context of the Borana pastoralists would properly guide HIV/AIDS communication and prevention strategies. Overlooking local contexts cannot bring behavioural change concerning HIV/AIDS (Iwelunmor, Newsome & Airhihenbuwa 2013). Generally, developing a community-specific conceptual framework is vital because of the following pillar principles based on the literature findings:

- One of the principles is that the target community should own the process and content of communication (cultural engagement).
- The second principle recommends that communication should empower the marginalised part of the population; the voices of the unheard population group should be given attention in HIV/AIDS communication.
- Thirdly, the principle states each community member should be given the opportunity to participate in the development affairs of their locality.
- Fourthly, the principle argues that emphasis should shift from persuasion, and the transmission of information from outside technical experts to issues that resonate with the members of the community.
- Lastly, the principle states that communication should look beyond individual behaviour to social norms, culture, gender, religion, spirituality, and the supporting socio-cultural environments.

HIV/AIDS prevention should consider culturally sensitive communication approaches (Brooks, Manias, & Bloomer 2019). This means considering the Indigenous contextual domains that play a significant role in addressing social problems. Local resources, like cultural institutions, should be integrated with the lives of the target population. In the context of this study, HIV/AIDS communication among the Borana pastoralist community should consider the contextual domains in the local community (Williams, Wyatt & Wingood 2010; Iwelunmor, Newsome & Airhihenbuwa 2013; UNAIDS 2001). Accordingly, based on the literature, the following conceptual framework was developed for the Borana pastoralist community to address contextualised, cultural path of HIV/AIDS communication.

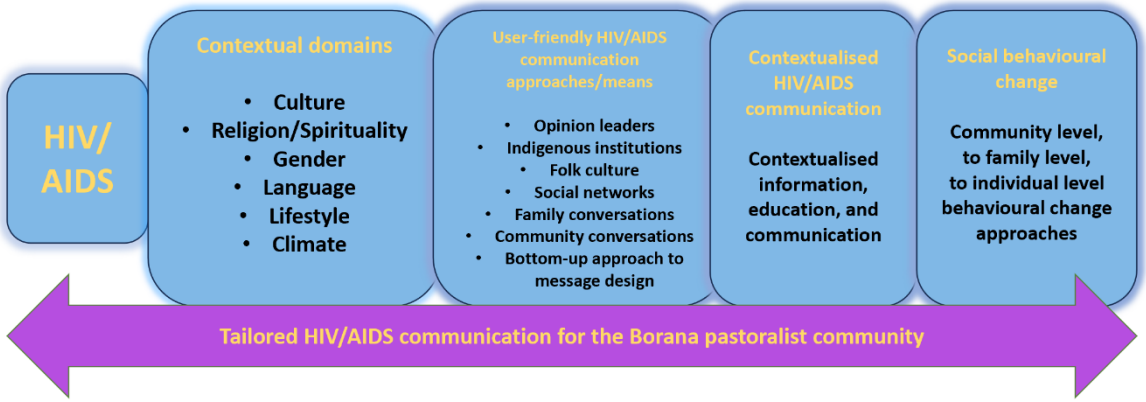


Figure 4.2: Conceptual framework of HIV/AIDS communication for Borana pastoralists

The conceptual framework pays attention to understanding the local contexts for effective HIV/AIDS communication in Borana. These contexts include culture, values, norms, religion/spirituality, gender roles and expectations, language, climatic conditions, and the pastoralists' livelihoods to address effective and user-friendly HIV/AIDS messages. In Borana, the pastoralist community healthcare workers (health system) should undertake user-friendly approach to HIV/AIDS communication. The epidemiological aspects of HIV/AIDS communication alone cannot bring the social behavioural change unless an appropriate approach to communication is followed. Accordingly, major tenets of the conceptual framework are explained below.

4.4.1 Cultural context

HIV/AIDS is both a biomedical disease and a social phenomenon that is constructed in specific cultural contexts (Mabweazara, Ley & Leach 2018). Pastoral communities are characterised by early sexual debut, early marriage, and the prevalence of potentially harmful traditional practices such as extramarital sexual relations, polygamy, female genital circumcision, and widow inheritance (Van der Kwaak et al 2012). These harmful traditional practices fuel the spread of HIV/AIDS among the culturally bound Borana pastoralist community. The communication needs to consider social and cultural values, norms, belief systems, Indigenous resources, art, morals, traditional laws, and customs of the Borana pastoralist community for effective health behavioural change (Khandu, Tobgay & McFarland 2021). The positive socio-cultural resources and social networks should be integrated into the community-based HIV/AIDS communication (Raeff et al 2020; Passaro, Castañeda-

Huaripata, Gonzales-Saavedra 2019). This means attributes of a culture that will support HIV/AIDS prevention programmes should be identified and harnessed. The symbolic combination of culture and barriers need to be uncovered, deconstructed, and reconstructed so that new positive cultural linkages can be forged (Obregon 2000:322). HIV/AIDS prevention programmes should engage the Borana cultural resources. Engaging culture is a dimension of participatory approaches that genuinely begin where people are and work with them to address aspects of their life that they identify as important (Achen, Atekyereza & Rwabukwali 2021; Okechi 2018). HIV/AIDS prevention needs to create space for the local people to reflect on their situation and find pathways of change which work in context, rather than the dissemination of messages, which may often be quite unrepresentative (Okechi 2018).

4.4.2 Religious/spiritual context

Traditional medicine and faith healing are practised among the Borana pastoralist community to cure diseases such as HIV/AIDS. Religion and spiritual dimensions can promote and help to establish a beneficial relationship between quality of life and spiritual well-being (Monteiro et al 2020). Religion/spirituality includes values and beliefs about what is morally right or wrong. Religious institutions and doctrines have their own contribution to promoting societal health. Hence, positive religious/spiritual resources should be integrated into the community-based HIV/AIDS communication for effective behavioural change. The prevention strategy should systematically tackle religious beliefs and practices that may aggravate the spread of HIV/AIDS. The deeply rooted traditional beliefs about HIV/AIDS in the Borana pastoralist community should be addressed for effective social behavioural change.

4.4.3 Gender context

In the Borana pastoral community, there is a deeply rooted gender-based classification and role assignment (Anbacha & Kjosavik 2019). In addition, there is gender-based discrimination that exposes especially women to different social-economic disparities and health problems. The place of a man and woman is not equal in the culturally bound Borana pastoralist community. Gender inequalities and power relations reduce economic and social opportunities among women and increase risky sexual behaviour (Sia et al 2016; Mbonye et al 2012).

Hierarchical gender roles such as notions of male sexual entitlement, the low social value and power of women, and ideas of manhood linked to the control of women, result in lower levels of education among women, fewer public roles for women, the lack of family, social, and legal support for women, as well as the lack of economic power for women (Ramjee & Daniels 2013). HIV/AIDS communication in the Borana pastoral community should therefore pay attention to the deeply rooted gender contexts that expose the local community to the problem of HIV/AIDS. The gender issue of HIV/AIDS should be seen from the pastoralist culture as it imposes unique problems on women. In the pastoralist community, especially women have a double burden due to gender discrimination and climate change. Thus, HIV/AIDS prevention programmes and communication in the pastoral community should consider gender in the context of pastoralism and the pastoralists' livelihoods.

4.4.4 Lifestyle/livelihoods

Pastoralism remains a way of life in many geographic areas of Africa like the Borana pastoralists in Ethiopia. There are links between HIV/AIDS and agricultural-based livelihoods such as pastoralism. Morton (2006) stated that the pastoral livelihood is characterised by mobility for grazing, livestock marketing, food insecurity, vulnerability to adverse policy, droughts, isolation from health services, reliance on collective action, labour intensive, and risky marketing chains which expose the different health problems including HIV/AIDS. This implies HIV/AIDS communication in the pastoral community of Borana should suit the livelihoods and lifestyle of their community.

4.4.5 Language context

Language is one aspect of culture. It shapes how people think about a disease; communication shapes the health behaviour and experiences of the target population (Lynn 2017). Language use is therefore linked to effective HIV/AIDS communication. Language clarity improves health communication outcomes. Miscommunication may occur because of language-relate barriers. One's language environment and experience can impact the representation of meaning (Nissen & Meuter 2023). In the context of the multilingual communities like Ethiopia, linguistic barriers continue to be a source of difficulty and leads to inappropriate treatment in healthcare services (Wakuma& Teresa 2020; Kebede et al 2020).

This means language barriers are limiting the accessibility of healthcare services and quality of care (Lopez Vera et al 2023). Many lower-and middle-income countries have high levels of linguistic diversity, meaning that health information and care is not available in the languages spoken by most of the population. The acknowledgement of language needs in formal planning and reporting (in the context of HIV/AIDS-related healthcare) is extremely low (Bachelor et al 2019).In HIV/AIDS communication among the Borana pastoralist community, language issues should be considered. The language of the target community should be appropriately used for communication effectiveness. The use of people-first language avoids stigmatisation and discrimination of people with a socio-economic disadvantage and increases the focus on the individual and community (Lynn 2017). Both verbal and non-verbal languages should appeal to the interests and contexts of the local community. Language that is used to communicate HIV/AIDS information should also address the interests of men and women, regardless of the gender differences. The language use should be inclusive and entertain the interests of the local community equally. Folk media/tradition such as storytelling, proverbs, visual art, drama, role-play, concerts, songs, and dancing should be properly integrated with the language of Borana to address effective HIV/AIDS messaging.

4.4.6 Climate

Climate change affects human health both directly and indirectly (Herrero et al 2016). Droughts affect most people living in the Horn of Africa with increasing frequency and duration. It impacts health and is exacerbated by these regions' low adaptive capacity (Herrero et al 2016). Herrero et al (2016) indicated that social vulnerabilities, especially high HIV prevalence, unemployment levels, and gender inequality further complicate the ways in which droughts, and other climate and weather conditions, affect the populations in pastoralist areas of Africa. During long droughts in the pastoralist community, people are forced to travel greater distances to access enough grazing lands. This may lead to livestock deaths and increases ethnic violence, as well as health risks including HIV/AIDS (Lumborg et al 2021). Negative health impacts on the pastoralist community indirectly stemmed from decreases in livestock production and increases in water scarcity. Poorly resourced healthcare facilities with limited accessibility, combined with an absence of health education amplify the pastoralist community's vulnerability to health challenges such as HIV/AIDS (Lumborg et al 2021).

The health services including HIV/AIDS information, education, and communication in the pastoralist community is poor during long droughts. The relationship between the pastoral community and healthcare workers during long droughts is threatened because of the adverse climate effects like shortages of water and famines. This implies HIV/AIDS communication should consider climate issues and address the health needs of the pastoralist community during hardship as well. There is a need to develop a pastoralist-friendly health system and work culture that suits the pastoralist context.

4.4.7 User-friendly communication approaches

Contextualised communication is part of healthcare services. Evidence-based communication targeted to an audience, for a specific purpose, based on an audience's known needs and preferences is an extremely powerful tool for tackling complex health challenges such as HIV/AIDS (Olufowote 2021). HIV/AIDS communication approaches need to be suitable to the contexts and lifestyle of Borana pastoralists. HIV/AIDS communication (message design, language use, content and format, channel, time, place) should consider the unique features of pastoralism and the pastoral community in Borana. In health communication, the PEN-3 cultural model is a culture-centred approach (Olufowote 2021). It uses a forest and tree metaphor to contrast a culture-centred approach to health communication with the traditional individual-level approach (Olufowote 2021). Olufowote (2021) also stated that culture-centred approaches focus on how the form of the forest and the roles and relationships among trees, rather than a single tree, shape health beliefs and behaviours. Unlike other models (like the ecological models), the PEN-3 culture-centred approaches focus on communities that reside at local and global margins (Olufowote 2021). Thus, HIV/AIDS communication among the Borana pastoralist community should consider not only the tree (HIV/AIDS), but also the forest (socio-cultural contexts) for effective message delivery and social behavioural change. HIV/AIDS communication among the pastoralist community should be participatory and encourage open dialogue (Mtenga et al 2016). The communication should not be top-down, expert-dominated, authoritarian, and unidirectional that is characterised by vague warnings and persuasive communication. HIV/AIDS programme planners and/or healthcare workers should include the opinion leaders/influential personalities such as *Gadaa* leaders, elders, and religious leaders for effective social behavioural change concerning HIV/AIDS. The communication needs to use the Borana oral traditions (folk culture) such as cultural proverbs, drama, tales, riddles, songs, and dances to address contextualised HIV/AIDS messages that can appeal effectively to the local community.

4.4.8 Contextualised HIV/AIDS information, education, and communication (IEC)

The IEC is one of the common health communication strategies in sub-Saharan Africa (Adebisi, Rabe, & Lucero-Prisno 2021). Conventionally, the IEC approach is used in the field of reproductive health to create awareness, increase knowledge, change attitudes, and move people to change their behaviour or adapt an innovation. However, IEC is externally funded and art-based health promotion campaigns, adopted from "western educated industrialised rich democratic contexts" (Adebisi, Rabi & Lucero-Prinso 2021). In the context of the developing countries health, IEC communication strategies lack coherence and contexts of the collectivist culture. Health programmes fail because of the lack of appropriate information, education, and communication for the target audiences (Acharya, Devkota & Gautam 2020). Health IEC should inform, inspire, motivate, enable, and empower people to decide the healthy way by making changes in terms of knowledge, attitudes, beliefs, and positive practices (Acharya, Devkota & Gautam 2020). In HIV/AIDS communication among the Borana pastoralist community, disseminating HIV/AIDS information, education, and communication materials is not enough. IEC should consider the contextual domains like culture, gender, religion/spirituality, language, literacy, and similar issues of the target people. The IEC strategy for HIV/AIDS prevention should be contextualised in such a way that it is tailored to the socio-cultural contexts of the larger Borana pastoralist community to promote the community's knowledge, awareness, beliefs, and positive behaviours about HIV/AIDS.

4.4.9 Social behavioural change communication (SBCC)

In the context of the Borana pastoralist community, HIV/AIDS communication should be participatory, focusing on social behavioural change. Behaviour change communication should use tailored messages and a supportive environment to make positive health behaviour changes among the target community (Akobi, Oyore & Otieno 2022).The behavioural change communication should focus on the larger socio-cultural contexts of Borana pastoralists that influence the individual's health behaviour. In a collectivist culture, like the Borana pastoralists, SBCC intervention is a pivotal part of the comprehensive HIV/AIDS prevention response that helps to address aspects of underlying behavioural and social barriers that drive the epidemic (Akobi, Oyore & Otieno 2022). Social behavioural change intervention also plays a critical role in expanding knowledge of, and access to, quality health services, strengthen equity and participation, and assist in addressing health

disparities, thereby creating an enabling environment (Lamstein et al 2014). A contextualised SBCC is vital to increase the performance of positive health behaviours (Akobi, Oyore & Otieno 2022). Targeted behaviour changes communication strategies, designed specifically for the collectivist cultural community of the Borana pastoralist, is needed to address HIV/AIDS prevention and promote social behavioural change (Akobi, Oyore & Otieno 2022). In addition, in the context of HIV/AIDS prevention among the Borana pastoralist community, the communication should focus on the larger cultural group: community, and then the family and the individuals. This is because in the collectivist culture of Borana, individual behaviour is influenced by the larger cultural groups. Community-based HIV-prevention services are a key approach to prevent HIV transmission among the culturally bound population (Neduzhko et al 2023). The focus of HIV/AIDS communication should be on the larger community, then on the family and individuals to bring positive behavioural change concerning HIV/AIDS. Andrew (2015) states that community mobilisation, as a pillar of the international HIV/AIDS policy and intervention, is considered vital to the culturally bound community. This implies that it is crucial to translate externally conceived HIV/AIDS management approaches into locally appropriate discourses and practices (Andrew 2015). People's experiences of, and responses to, HIV/AIDS are embedded in the local worldviews and survival strategies that have a poor fit with the biomedical and behavioural frame of reference that dominate globally conceived programmes (Andrew 2015). HIV/AIDS communication in Borana needs to promote community-based, pastoralist-friendly, participatory approaches of disease prevention to bring social behavioural change. Generally, HIV/AIDS communication and prevention strategies among the Borana pastoralist community need to follow the bottom-up approach that engage and empower the local community to develop their own health. The health system in general and HIV/AIDS communication strategies, need to understand the pastoralists' livelihoods and unique features. For effective HIV/AIDS communication, it is important to focus on the collectivist culture of the target community. Therefore, the socio-cultural path of HIV/AIDS communication (tailored HIV/AIDS communication) is crucial among the Borana pastoralist community for effective social behavioural change to occur.

4.5 CONCLUSION

This study contributes a conceptual framework to tailor HIV/AIDS communication to the context of the Borana pastoralist community. The conceptual framework outlines major domains that need to be considered for effective HIV/AIDS communication. These domains include socio-cultural contexts, user-friendly communication approaches, contextualised information, education, and communication, as well as community-oriented social

behavioural change. To curb the spread of HIV/AIDS and promote social behavioural change among the Borana pastoralist community, the focus should be on what the community already has, such as the socio-cultural resources, indigenous institutions, social networks, and the livelihood of the community. A community-oriented integrative HIV/AIDS communication approach is crucial to tailor the messages to the context of the target pastoral community in Borana. Hence, the cultural path to a HIV/AIDS conceptual framework is applicable in the context of the collectivist cultural community of the Borana pastoralists for effective social behavioural change to occur.

Conceptual frameworks are often developed for specific situations or research questions, which means they may not be useful in other contexts. Sometimes conceptual frameworks can be too simplistic or narrow in scope, which can limit their usefulness in complex situation. The presents study is based on a qualitative case study. The conceptual framework is also developed based on the specific HIV/AIDS communication in Borana pastoral community. Thus, the framework developed for the Borana pastoral community may not be adequate for other cultural contexts like urban culture and / or non-pastoral community. In addition, the conceptual framework is developed based on micro contexts with limited variables. The conceptual framework did not address the structural or policy level macro issues such as economy and politics in relations to HIV/AIDS communication. Chapter 5 presents research methodology.

CHAPTER 5
RESEARCH METHODOLOGY

5.1 INTRODUCTION

This chapter presents the methodological orientation for this study. A qualitative case study research design was used to carry out an in-depth study concerning the cultural embedment of HIV/AIDS communication in the Arero district in Borana, Ethiopia. The research paradigm that guided this study was also discussed in this chapter. Yin's (2009) case study design protocol, together with Neuman (2000) and Stake (1995), was adapted to undertake the case study research. Multiple methods of data gathering were used, including in-depth interviews with cultural leaders, religious fathers, and healthcare workers, focus group interviews with female households and male households, and document analysis. A description of the study area is given to provide information on the geographical as well as socio-cultural background of the participants. In addition, this chapter describes how the participants were identified and sampled for this study. The characteristics of each data collection method used were also explained. The chapter also outlines the development of in-depth interviews, focus group interviews, and document analysis routes. Furthermore, procedures during data collection such as data organisation, transcription, translations, categorisation, analysis, triangulation, and interpretations are discussed. In addition, quality assurance mechanisms and ethical considerations are explained.

5.2 RESEARCH PARADIGM

This study is guided by the social constructionist (interpretivist) research paradigm. Constructivism (interpretivism) argues that meaning is embedded within the social and historical contexts (Mertens 2008). Meaning is formed through interactions with others (social constructivism) and through historical and cultural norms that operate in individuals' lives (Cresswell 2009). Thus, constructivist (interpretivist) researchers often address the processes of interaction among individuals. Interpretivist researchers focus on the specific context which people live and work in, to understand the historical and cultural settings of the participants (Lincoln, Lynham & Guba 2011).

In the constructionist paradigm, "researchers recognise that their own backgrounds shape their interpretation, and they position themselves in the research to acknowledge how their

interpretation flows from their personal, cultural, and historical experiences. The researcher's intent is to make sense of (or interpret) the opinions others have about the world. Rather than starting with a theory (post positivism), inquirers generate (or inductively develop) a theory or pattern of meaning" (Lincoln, Lynham& Guba 2011:12). Therefore, the social construction paradigm (interpretative) is applicable to this study. This paradigm is helpful to guide the study as it considers people and their interpretations, perceptions, meanings, and understandings, as the primary data sources (Mason 1996:56). Interpretivism is based on issues like philosophies, experiences, and human activities (Leitch, Hill & Harrison 2010).

In interpretivist views, investigation of the social world consists of subjective reality (Cresswell 2009). Interpretivism views are crucial to study the subjective interpretations of social meanings about HIV/AIDS communication among the Borana pastoralist community in the Arero district. In addition, the interpretive paradigm is epistemologically applicable to this study. In the context of this paradigm, the world can be best understood, not from an objective point of view, but from a subjective perspective. The viewpoint of the interpretive paradigm is that reality is the result of human actions (Leitch, Hill & Harrison 2010). The interpretivist paradigm is concerned more with relevance than dogmatism. This paradigm is epistemologically relevant for the study to understand how the Borana pastoralist community in the Arero district constructed their own meaning from the HIV/AIDS communication. Thus, this study intended to understand the socio-cultural meanings exchanged in the interpretive processes during the HIV/AIDS communication with the Borana pastoralist community. The interpretivism view is helpful for this study to analyse meaning produced in the processes of HIV/AIDS communication among the Borana pastoral community in the Arero district (Flick 2015:24). The symbolic interaction perspective of the interpretative paradigm is vital to understand the nature of the present study.

5.3 QUALITATIVE RESEARCH DESIGN

A qualitative case study research design was used in this study. Mack et al (2005:3) stated that qualitative research helps to collect data systematically and to obtain an in-depth understanding of the subject under investigation. Qualitative research is vital to in-depth investigation (Cresswell 2009). It is crucial to understand the problem from the viewpoint of the target group. A qualitative research approach is crucial to understand culturally specific information (Mack 2005).

In addition, a qualitative research design helps to understand the lived experiences of people. A detailed investigation of the socio-cultural issues is possible through a qualitative study. Socio-cultural systems frame social reality (Denzin & Lincoln 2008:13). This means that the lived experiences of a society can be best studied within the socio-cultural context. The socio-cultural context is vital to understand social realities, including social health. For this study, a qualitative research design is applicable to explore the integration of HIV/AIDS communication into the socio-cultural contexts of the Borana pastoralist community in the Arero district. In addition, qualitative research allows for the provision of community-based insights into sensitive socio-cultural issues such as social norms, values, belief systems, language, gender, religion/spirituality, and sexual orientations related to HIV/AIDS (Morgan & Fonseca2004). Therefore, a qualitative research design was applicable to explore the appropriateness of HIV/AIDS communication among the Borana pastoralist community from the socio-cultural domains.

Qualitative field research is used to understand the lived experiences of the research participants (Babbie 2007:286). Field research is suitable to study the lived experiences of people from their viewpoints, cultural values, norms, gender, religion, spiritual orientations, and symbolic constructs (Patton 1990). In the context of this study, qualitative field research used data collection methods, namely in-depth interviews, focus group interviews, and qualitative document analysis. An in-depth interview is essential in qualitative research. In-depth interviews are pertinent to study an individual's lived experience in detail. (Cresswell 2009). Focus group interviews are also a crucial technique to gather data in an orally dominated society such as the Borana pastoralist community. Focus group interviews help to gather detailed qualitative data in a natural group interaction. A qualitative document analysis is a logical process to review or evaluate documents. In document analysis, textual data is examined and interpreted to elicit meaning, gain understanding, and build up practical knowledge (Corbin & Strauss 2008). In this study, HIV/AIDS policy documentation was analysed and interpreted in line with the research objectives. The in-depth interviews and focus group interviews were crucial to have direct and close contact with Borana pastoralist female and male households, cultural leaders, religious fathers, and healthcare workers. The close relationship between the researcher and research participants was essential to gather detailed and relevant qualitative data in a natural setting. In addition, HIV/AIDS policy document analyses supported the qualitative data gathered using in-depth and focus group interviews. The case study research is presented in the next section, as well as the advantages of a qualitative research design.

5.3.1 Advantages of qualitative research design

Qualitative research provides a detailed understanding and analysis of limited cases (Flick 2015). In qualitative research, the participants have more freedom to determine what is relevant for them. It helps the researcher understand how people experience a given research issue, and it provides information about human behaviours, beliefs, opinions, emotions, and relationships (Natasha et al 2005:4). Human factors such as social norms, gender roles, ethnicity, religion, spirituality, and identity orientations can be studied more qualitatively (Du Plooy & Du Plooy 2009). Understanding the complex reality of a given situation is possible through qualitative study. Qualitative methods in exploratory research can use open-ended questions and probing to develop a detailed understanding (Mack et al 2005:6). Open-ended questions and probing give the participants the opportunity to explain issues using their own words (Cress well 2009:37). Qualitative data provides rich information and is essential to understand a specific population when the result cannot be generalised to a population outside of the study area (Mack et al 2005:5). In the following paragraphs, qualitative field research is explained.

5.4 CASE STUDY RESEARCH

A case study design was used for this research. The case study was pertinent for an in-depth understanding of the cultural embedment of HIV/AIDS communication among the Borana pastoralist community in the Arero district (Flick 2015:193). Cress well (2009:46) explains that a case study, as a strategy of inquiry, is used to undertake the in-depth study of a programme, an event, activity, a process or one or more individuals. Yin (2014) sees a case study investigation as dealing with a technically distinctive situation in which there may be many more variables of interest than data points using different sources of evidence. That case study research can employ the use of different sources of data. It comprises of inclusive methods covering the logic of design, data collection techniques, and specific approaches to data analysis. These designs are not limited to data collection techniques alone, or any given design feature, meaning that a case study has its own principles for issues like site selection, sample determination, data collection, data saturation, data analyses, interpretation, and discussions (Yin 2009). Case studies can be conducted and written with many different intentions. This intention may be to understand an individual case, or to arrive at a broader generalisation using multiple cases. In the context of this study, a single case study with multiple sources of data, namely in-depth interviews, focus group interviews, and qualitative

document analyses were used. Therefore, a case study design was suitable to explore the socio-cultural embedment of HIV/AIDS communication in the case of the Borana pastoralist community in the district of Arero.

5.4.1 Determining the case study type

This study is based on a single case study approach with embedded units (Yin 2009). It includes units from different participants, such as cultural leaders, religious fathers, health care workers, male households, as well as female households. Case study research can use a single case, or multiple cases. When a study includes more than one case, a multiple case study is needed. In this study, the researcher had chosen to use the single case study of the Arero district in the Borana zone, with embedded units. This gives the researcher the ability to look at sub-units that are located within a larger case (Yin 2009). “The selection of a single case study design plays crucial role to make an in-depth investigation, apply different data gathering sources for triangulation, get insights into social processes and experiences, and study social experiences and practices that were not previously accessible to wider audiences” (Yin 2009). Case study research is more focused on the “why” and “how” research questions. The present study addressed the “why” and the “how” questions in the quest to explore the socio-cultural appropriateness of HIV/AIDS communication in the target study area.

In case study research, a researcher can determine a research question that addresses the objective of the qualitative case study. Research questions should be set, based on the nature of the case study to be conducted. The selection for a specific type of case study design is guided by the overall study purpose (Yin 2009). The researcher should be clear whether he/she attempts to explain a case, explore a case, or compare between cases. For instance, an explanatory type of case study is used to answer a question that required an explanation of the supposed causal links in real-life interventions that are too complex for survey or experimental strategies (Yin 2009). Exploratory case study is used to explore those situations in which the variables being assessed have no clear single set of outcomes (Yin 2009). Descriptive case study is used to describe an intervention or phenomenon and the real-life contexts (Yin 2009). Therefore; exploratory case study was used to explore the socio-cultural embedment of HIV/AIDS communication among the Borana pastoralist community in the Arero district, Borana zone. The researcher was interested in looking at the same issue within one community.

The case study with embedded units enabled the researcher to explore the case under investigation in detail. The ability to engage in a rich analysis serves to better clarify the case (Yin 2009). Therefore, this single case study approach uses an exploratory type of case study with holistic cases and embedded units to enable the researcher to explore the case in detail. Individual units such as cultural leaders, religious fathers, healthcare workers, as well as male and female households in the Arero district are participants of the study. The next section presents case study protocol.

5.4.2 Case study protocol

Case study protocol helps to guide the case study research procedure (Yin 2009). The protocol directs the researcher during the research process. In addition, case study protocol helps to keep uniformity in data collection and analysis when data is to be collected in multiple locations. Case study procedure contains the research instrument(s) (Yin 2009). Accordingly, case study protocol should outline the procedures and rules that govern the conduct of the research. Despite the claimed importance of case study protocols, there appear to be very few established protocols published in literature related to case research. However, Yin (2009) and Eisenhardt (1989) recommended case study protocol as explained in the section below.

5.4.2.1 Sections of case study protocol

A case study protocol consists of important parts. These parts are interrelated and help to inform the researcher of the appropriate and ethical procedure in collecting data. Each of these sections is discussed below:

Preamble

The case study protocol contains an introduction that guides the research participants in the Arero district before the data collection. The introduction section of the protocol contains general information about the protocol, guidelines for data collection, document storage, and publication (Yin 2009, 2003, 1994).

General

The general section mainly deals with the aim, purpose, and objectives of the study (Yin 2009, 2003, 1994).The general section informs the research participants in the Arero district about the aim, purpose, and objectives of the study.

Procedures

The third section of the protocol describes the procedures and way the researcher contacted the organisation and/or relevant people for the study. This includes a work schedule as well as organising the necessary facilities for the field visit (Yin 2009). Prior to data collection, the researcher followed a formal communication procedure. First, an ethical clearance letter was obtained from the University of South Africa to begin the field research. Then, the researcher obtained a support letter from Ambo University. Next, the Borana zonal administration issued the researcher with a support letter to collect data from the participants in the Arero district. During this study, relevant offices at the district level (Arero District Cultural and Tourism office, Arero District Health office) were notified through the Arero district administration to provide the researcher with the necessary information. Moreover, *kebele* level participants were notified about the purpose of the study through the Arero district administrative office so that the *kebele* level administration could coordinate the participants for the data collection. Then, oral consent was received from the participants before the data collection. The consent stage was the stage where they agreed to participate in the data collection processes.

Research instrument

This section is the stage of administering actual research instruments. In this case, research instruments such as an in-depth interview route, focus group interview route, and a document analysis guideline were developed. The use of more than one data source is a technique that caters to the process of triangulation. Triangulation increases both the reliability and validity of qualitative research (Yin 2009; Neuman 2000). “Data from multiple sources was analysed using deduction techniques to achieve convergence on a given set of facts” (Yin 2009). This study made use of three data collection methods, adhering to the case study research design, as well as ensuring that data triangulation occurs.

5.5 BORANA FIELD VISIT

The researcher visited the Borana pastoralist community in 2017. The visit was with the consent of the Borana zonal administration office. The aim of the visit was for familiarisation. The field visit assisted the researcher to develop data gathering instruments, identify the Borana language dialects and cultural norms, and prepare appropriate questioning routes to collect relevant data. Accordingly, semi-structured questioning routes were developed for both FGIs and in-depth interviews.

5.6 DATA SOURCES

This study used both primary and secondary data sources. Primary data sources were the in-depth interviews and focus group interviews with the research participants (cultural leaders, religious fathers, healthcare workers, as well as male and female households). However, the HIV/AIDS policy document of Ethiopia was used as a secondary data source. The policy document was analysed to support the primary data (Creswell & Creswell 2017). Yin (2009) stated that case study research can use multiple sources of data to understand the specific issue in detail. Accordingly, the data from different sources (in-depth interviews, focus group interviews, and document analysis) ensure that triangulation was followed in this study to further verify the data obtained. Data-gathering techniques used in this study are discussed in the subsequent section.

5.7 IN-DEPTH INTERVIEWS

In-depth interviews are one of the most common forms of data gathering in qualitative research (Denzin & Lincoln 2008). It is important to obtain in-depth information about an individual's experience (Rubin & Rubin 2011). In-depth interviews are appropriate for exploring phenomena which we have limited knowledge on, or in generating knowledge to inform social or healthcare interventions (Treweeket al 2017). In-depth interview questions are primarily open-ended and lead to a discovery-oriented approach. The purpose of in-depth interviews is to obtain detailed information that sheds light on an individual's perspective, experiences, feelings, and the derived meaning about a topic or issue (Denzin & Lincoln 2008). In this study, the qualitative data was collected from the cultural leaders, religious leaders, and healthcare workers via in-depth interviews. These focused on the lived experiences of the key personalities to consider the socio-cultural appropriateness of

HIV/AIDS communication among the Borana pastoralist community. Accordingly, a semi-structured interview schedule was used to gather in-depth qualitative data from the participants.

Employing in-depth-interviews was important as it provided opportunities for the participants to express their ideas on the issue of HIV/AIDS communication from the socio-cultural approach in the context of the pastoral community in Borana. The in-depth interviews provided more in-depth information, opportunities to observe non-verbal behaviour of respondents, gave opportunities for clearing up misunderstandings, as well as meet many diverse situations pertaining to HIV/AIDS communication from cultural, religious/spiritual, and gender points of view (Rolón-Dow & Bailey 2021).

In-depth interviews are considered a form of unstructured interviews. Stories that document the experiences of individuals are central to in-depth interviews (Rolón-Dow & Bailey 2021). An in-depth inquiry helps the researcher to study the life of individuals through the storytelling method (Greenberg & Elliot 2004; Makalela 2015). In-depth interviews place the people being interviewed at the heart of a research study (Anderson & Kirkpatrick 2016). In health research, in-depth interviews are a means of collecting people's own stories about their experiences of health and illness (Anderson & Kirkpatrick 2016). In-depth interviews can help researchers to better understand people's experiences and behaviours as they typically use an unstructured form of interviewing. Unstructured interviewing allows the participants to tell their own story, in their own words, with prompting by the interviewer. The objective of an unstructured interview is to elicit rich and detailed materials that can be used in qualitative analysis.

For instance, an episodic in-depth interview is a qualitative method that is useful to the researcher who is new to the domain of a narrative-focused research (Mueller 2019). An episodic in-depth interview is also a systematic-focused approach that is used to encourage research participants to convey bounded stories about their experiences of a phenomenon. The structure of an in-depth interview is intentionally designed based on principles of experiences of the participants (Squire 2013; Dwyer, Davis & Emerald 2017:228). Therefore, in this study, an in-depth interview method of data collection was useful to address the first and second objectives of the thesis.

Du Plooy and Du Plooy (2009:143) asserts that an in-depth interview/detailed story idea is an essential qualitative method to discover subjective views of the participants.

Unlike other interview types, in-depth interviewees present longer, detailed, and more coherent accounts of their experience on an issue. In-depth interviews envisage setting to encourage and stimulate interviewees to tell stories or share ideas about some significant events (Bauer 1996:3). The basic idea of an in-depth interview is to reconstruct social events from the perspective of informants as direct as possible. Storytelling techniques enable the researcher to study participants' experiences within the social, cultural, and institutional settings. An in-depth interview method forms part of the socio-cultural theory, as it is vital to study the socio-cultural experiences of research subjects (Moen 2006:4).

In this study, the in-depth interviews were conducted with cultural leaders, religious fathers, and healthcare workers in the Borana pastoralist community. The in-depth interviews with the cultural leaders were mainly to investigate the embedment of HIV/AIDS communication into the socio-cultural and gender contexts. The in-depth interviews with the religious leaders were mainly to investigate the embedment of HIV/AIDS communication into the religious/spiritual contexts of the community. Finally, the in-depth interviews with the healthcare workers were to investigate experts' views on the community practices regarding the community-based HIV/AIDS communication. The involvement of healthcare workers was vital to identify HIV/AIDS communication approaches in action and the nature of messages conveyed to the target community. Therefore, an in-depth interview method of data collection was applicable to explore the relevance of HIV/AIDS messages to the contextual domains of the Borana pastoralist community in the Arero district. The next sub-topic discusses the specific characteristics of in-depth interviews.

5.8 FOCUS GROUP INTERVIEWS (FGIs)

In this study, focus group interviews were conducted with female and male households in the Arero districts of the Borana zone. The focus group interviews were used to unpack the lived experiences of the group participants concerning the socio-cultural appropriateness of HIV/AIDS communication (Du Plooy & Du Plooy 2009:201). The researcher moderated the focus group interviews. A semi-structured focus group interview schedule was prepared to gather in-depth information. The focus group interviews were documented with the consent of the participants (Harrell & Bradley 2009). The interviews were carried out in the native language of the participants, which is Afan Oromo. The language consideration was helpful to eliminate the alienation of the messages, to make the messages culturally appropriate, understandable, and acceptable (Ahmad 2012).

Krueger and Casey (2000) stated that FGI offers several advantages. It encourages and captures interaction among participants. The interaction provides the researcher with a chance to observe how people influence one another and how they talk about specific topics (Krueger & Casey 2000). This technique provides information that is difficult to obtain with other methods. In addition, the focus group format allows the moderator to probe for additional information at critical points. FGI discussions have high face validity. This means clients can easily understand the technique and typically find the results credible. Finally, FGIs enable researchers to increase the sample size of qualitative studies without dramatically increasing the time required to conduct them. This means that a group of people need to come together to converse on specific issues. In this study, FGIs were helpful to bring together male households and female households to discuss the socio-cultural appropriateness of HIV/AIDS communication among the Borana pastoralist community. The FGIs were helpful to encourage and capture interactions among the participants, allowing the moderator to probe for additional information, to cross-check for information clarity while the participants converse, and collect rich data by using verbal and non-verbal communication (Krueger & Casey 2000).

5.9 DOCUMENT ANALYSIS

Qualitative data can be gathered using a document analysis technique (Bowen 2009). Bowen (2009) indicated that a document analysis follows a systematic procedure for reviewing or evaluating documents based on the research objectives. In document analysis, data is examined and interpreted to elicit meaning and to gain an understanding about the material in terms of the subject being studied (Corbin & Strauss 2008). Document analysis may contain text (words) and images (Bowen 2009). In this research, document analysis was used to examine the socio-cultural embedment in the national HIV/AIDS policy document of the Federal Democratic Republic of Ethiopia.

The purpose of analysing the HIV/AIDS policy was to assess whether the policy documented the socio-cultural contexts of the target community in communicating HIV/AIDS messages. The document analysis provided supplementary research data. Information and insights derived from the document were valuable additions to the knowledge base. In addition, document analysis provided background and context, additional questions to be asked, supplementary data, a means of tracking change and development, and verification of findings in research (Bowen 2009).

The document analysis was used to support the primary data gathered through in-depth and focus group interviews. The following table presents contents of the national HIV/AIDS policy of Ethiopia for analysis.

Type of document	Contents	Nature of data	Type of analysis	Code
Ethiopia National HIV/AIDS Policy, 1999	1. Policy objective 2. Major contents 3. Communication strategies 4. Communication models/theories 5. Socio-cultural issues 5.1 Culture (including values, norms, belief systems, and language) 6. Religion/spirituality 7. Communication strategies 8. Gender 9. Communication approach	Qualitative	Qualitative content analysis/ Thematic analysis	Thematic coding technique

Table 5.1: Contents of national HIV/AIDS policy of Ethiopia for analysis
Source: Bowen (2009:36)

5.9.1 Document analysis checklist

Developing a checklist is essential for document analysis. The development of a document analysis checklist follows important steps that should consider the research objectives. For example, the document analysis checklist should be related to the basic research questions, include the form of the document, physical characteristics of the document, internal characteristics (content) of the document, relevance of the content, and the origin/source of the document (Mayring 2002). In this study, a checklist was developed to analyse the contents of the national HIV/AIDS policy document of Ethiopia, based on the research objectives. A questioning route was developed to direct the document analysis. Then the national HIV/AIDS policy document of Ethiopia was analysed in terms of the contextual domains like culture, religion/spirituality, gender, and HIV/AIDS communication strategies.

5.9.2 Procedures of document analysis

Document analysis usually follows an analytical procedure. This procedure entails finding, selecting, making sense of, and synthesising data contained in the document (Bowen 2009). Document analysis may use extracts, quotations, or entire passages. Major themes or

categories can be developed for document analysis (Bowen 2009). Document analysis can be used with interviews, focus group discussions, or observation (Yin 2009). In this study, document analysis was used with in-depth interviews and focus group interviews. The document analysis was used to support data collected through the primary data sources, namely in-depth and focus group interviews. The data from the document analyses was used together with the in-depth interviews and focus group interviews, in a triangulation fashion. In the context of this study, the policy document is to mean the contents of the material. The interest of the researcher is not to develop new policy through policy analysis, but to see whether the HIV/AIDS policy of Ethiopia is tailored to the socio-cultural contexts. Policy analysis is the process of identifying potential policy options that could address a problem and then comparing those options to choose the most effective, efficient, and feasible one which is not the focus area of this study.

5.10 RESEARCH ETHICS: PERMISSION TO COLLECT DATA

Research participants should provide their consent to be part of the study (Flick 2015). The participants are expected to give informed consent to participate (Flick 2015). This means the research participants had to be provided with clear information to make an informed decision whether to participate in the research activities. The research participants can provide their permission in writing. However, in this study the research participants gave their informed consent to participate in the study orally (Cresswell 2009). This research was conducted with the full ethical consent of the University of South Africa and other relevant institutions, such as the Ambo University, the Borana zonal administration and the Arero district administration, discussed in the next sub-topic. The researcher received the letter of consent before entering the field for actual data collection. In addition, the consent of FGIs and in-depth interview participants was achieved prior to data collection. Recording interviews was only with the consent of the participants. Part of the interview was recorded not to miss the essential points during the face-to-face interaction. Notes were taken for further discussions and interpretations.

5.11 SAMPLING AND SAMPLE SELECTION CRITERIA

The general population for this study included the Borana pastoralist community in the Arero district. The study was unable to include all the population in the district due to its qualitative nature (Du Plooy & Du Plooy 2009:108).

The pastoralist population in the areas are homogenous so that there was no need to include the different districts. As a result, sample population with identified parameters was used for this study. The following table summarises the target population, accessible population, population parameter, and unit of analysis in the context of this study.

Data gathering methods/tools	Target population	Accessible population	Population parameter	Units of analysis
In-depth interviews	Pastoralist community in the Arero district of the Borana zone	• Cultural leaders • Religious leaders • Healthcare workers	• Lived experiences within the Borana culture. • Exposure to HIV/AIDS communication. • At the age of five *Gadaa* grades or above 40 years.	Participants: • Cultural leaders/*Gadaa* fathers • Religious leaders • Healthcare workers
Focus group interviews	Pastoralist community in the Arero district of the Borana zone	• Female households • Male households	• Lived experiences within the of Borana culture. • Exposure to HIV/AIDS communication. • Participation in community affairs. • At the age of five *Gadaa* grade in Borana the culture (40 years and above).	Participants: • Female households • Male households
Document analysis	National HIV/AIDS policy of the Federal Democratic Republic of Ethiopia	Portion/s of the national HIV/AIDS policy document relevant to the research questions	The portion/s of the document relevant to the research questions	• Context units. • The portion of written material that is to be examined. • Context units can be the same as the units sampled.

Table 5.2: Data gathering tool, target population, accessible population, population parameter, and units of analysis.

Source: Du Plooy and Du Plooy (2009)

Table 5.2 above reveals that the target population for this study was the pastoralist community in the Arero district of the Borana zone. As the table indicates, a sample of cultural leaders, religious fathers, and healthcare workers in the Arero district participated in the in-depth interviews. The parameters for selecting the in-depth interview participants were:

- Their lived experience within the Borana culture, exposure to HIV/AIDS communication, and age of five *Gadaa* grade/40 years and above.
- The age of the participants was approximated to five *Gadaa* grade/40 years. This is a remarkable age in the Borana culture. At the age of 40 years and above, one is culturally expected to take on social responsibilities such as leadership and community consultations. In the Borana *Gadaa* system, which was registered by UNESCO in 2018, one is given a leadership role at the age of 40. Therefore, this study considered the age of the participants, based on *Gadaa* culture, to gather true data.
- The units of analysis for the in-depth interviews were cultural leaders, religious fathers, and healthcare workers.
- In addition, male and female households in the Arero district participated in the focus group interviews.
- Similar to the in-depth interviews, the participants of the focus group interviews were selected based on their lived experience within the Borana culture, exposure to HIV/AIDS communication, and age of *Gadaa* grade. The units of analysis for the focus group interviews were male and female households.
- The national HIV/AIDS policy document of the Federal Democratic Republic of Ethiopia was used to analyse the contents in line with the research objective. The document analysis helped to gain understanding and develop practical knowledge regarding the adequacy of the Ethiopian HIV/AIDS policy for effective communication (Corbin & Strauss 2008). Accordingly, the relevant content, appropriate for the research objectives, were selected (Bowen 2009). The unit of analysis in this document analysis was based on the thematic categories (context units). Context units were the portion of written material (the HIV/AIDS policy document in this study) that was examined about the research objectives.

5.12 SAMPLING PROCEDURE

This study used a non-probability sampling technique. Non-probability sampling is used when the participants are purposely selected to address the research objectives (Du Plooy &

Du Plooy 2009). In this study, a purposive sampling method was used. Purposive sampling was essential to collect data from well-informed sources (Cresswell 2009). The participants were included based on their knowledge and lived experiences within the Borana culture, and exposure to HIV/AIDS communication among the Borana pastoralist community in the Arero district.

5.12.1 Sampling frame

In qualitative research, samples are drawn from actual cases. In this case, understanding the sampling frame is essential (Cresswell 2009; Du Plooy & Du Plooy 2009). The sampling frame considers participants who have adequate knowledge and the lived experience of the subject for the study (Cresswell 2009; Du Plooy & Du Plooy 2009). Hence, in this study, the participants were included based on their lived experiences pertaining to HIV/AIDS communication within the Borana pastoralist community. In addition, the participants' understanding of the socio-cultural context of the Borana pastoralist community was considered. The participants were at the age of five *Gadaa* grade (40 years or above). Five *Gadaa* grade (40 years) in Borana culture is the age at which one is expected to hold social and administrative responsibility. Being *Abba Gadaa* (*Gadaa's* father) and *HaadhaSiinqee* (female cultural leader) is the stage at which one begins leadership and advisory responsibility of not only his/her family, but also the larger community. At this stage, the *Abba Gadaa* and *Haadha Siinqee* are expected to be honest and do justice for the people of all races. The *Gadaa* leaders and *Haadha Sinqee* never tell lies. This study therefore used a sampling frame from cultural leaders, religious leaders, healthcare workers, male households, and female households to collect the primary data.

5.12.2 Sample selection strategy

The researcher used the nomination strategy to select the participants (Krueger & Casey 2000). Nomination is a useful strategy in community studies. In this case, the researcher is free to ask neutral parties concerning who should participate in the study to provide the necessary information (Krueger & Casey 2000:7). The research participants are nominated based on the specifications of the researcher. In this study, the researcher visited the Borana zone in 2017 to familiarise himself with the study area. The visit was helpful to understand the pastoralist environments. In addition, the visit was useful to develop the questioning routes for the in-depth and focus group interviews.

The Borana zonal administration gave the researcher a letter of support to undertake the preliminary study for this research. As a result, based on the research objectives, the researcher identified the research participants for both in-depth and focus group interviews as per the inclusion criteria. The data for this study was collected from the participants with the assistance of the Arero district administrative office. The community leaders were keen to coordinate the participants for the research activities.

5.12.3 Sample size

In this study, four local *kebeles* (lower administrative structure) such as Mata Gafarsa, Guto, Renji, and Haro Dimtu were identified. As shown in Table 5:4 below, eight FGIs were held to collect data from male households and female households. This means four FGIs were composed of female households while the remaining four FGIs were composed of male households. The group size for each FGI was five individuals. However, the number of FGIs was determined by the concept of theoretical saturation. In addition, 15 informants (eight cultural leaders, four religious fathers, and three healthcare workers) participated in this study. Each in-depth interview took ninety minutes on average. The FGIs took place in a natural setting: the rural farmer training centre of the Arero district. The in-depth interviews with health professionals, however, took place in the office. The following table gives the summary of the explanations.

Data gathering methods	**Sampling strategy**	**Sampling type**	**Sampling method**	**Sample size**	**Sampling frame**
In-depth interviews	Nomination by the Arero District Administrative offices/Arero District Cultural and Tourism Development Office	Non-probability sampling	Purposive	Eight cultural leaders Four religious fathers Three healthcare workers	Lived experience within the Borana culture. Exposure to HIV/AIDS communication. At the age of five *Gadaa* grades and above (40 years and above).
Focus group interviews	Nomination by the Arero district administrative and *kebele*/village level administrator	Non-probability sampling	Purposive sampling	Four FGIs (20female households) Four FGIs(21 male households) Five	Lived experience within the Borana culture. Exposure to HIV/AIDS communication. Participation in community affairs. At the age of five *Gadaa*

				participants in each FGI on average	grades and above (40 years and above).
Document analysis	Contents of the national HIV/AIDS policy were identified based on the basic research questions	Non-probability sampling	Purposive	Contents of the national HIV/AIDS policy document suitable for the research context were identified, categorised, analysed, and interpreted in line with the basic research questions.	• Policy objective. • Major contents. • Communication strategies. • Communication models/theories. • Socio-cultural issues. • Culture (including values, norms, belief systems, language). • Religion/spirituality • gender • Communication approach for HIV/AIDS

Table 5.3: Sampling procedure

Source: Adapted from Du Plooy and Du Plooy (2009) and Bowen (2009)

5.13 DATA ANALYSIS METHOD: THEMATIC ANALYSIS

Data was analysed via a thematic analysis. Thematic analysis is the most widely used qualitative approach to analysing interviews and texts (Cresswell 2009). A thematic analysis is a method used for "identifying, analysing, and reporting patterns (themes) within the data" (Braun & Clarke 2006:79). In addition, this approach complemented the research questions by facilitating an investigation of the data from two perspectives: first, from a data-driven perspective and a perspective based on coding in an inductive way. Second, from the research question perspective to check if the data is consistent with the research questions and providing enough information (Braun & Clarke 2006:82).The thematic analysis in this study was driven mainly from the research question's perspective to address the research objectives. In the thematic analysis, the researcher followed some important interrelated phases to analyse the data based on Braun and Clarke (2006):

1. As the first step, the researcher should familiarise himself/herself with the data. It is vital that the researcher immerse himself/herself in the data to the extent that he/she will be familiar with the depth and breadth of the contents.
2. The second step is about the production of initial codes from the data. Codes identify a feature of the data (semantic content or latent) that appears interesting to the analyst, and refer to the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon being studied.
3. The third step entails searching for themes. At this point, the researcher starts to have a sense of the significance of individual themes as per the objective of the study.
4. Then, the researcher should review the themes based on the research questions. This involves the refinement of themes. Themes might also need to be broken down into separate sub-themes. At the end of this phase, the researcher should have a fairly good idea of what the different themes are, how they fit together, and the overall story they tell about the data.
5. The fifth step begins when the researcher has a satisfactory thematic map of his/her data for the final refinements. At this point, the researcher defines and further refines the themes that he/she presents for analysis and analyse the data within them. This phase also includes identifying the essence of what each theme is about (as well as the overall themes) and determining what aspect of the data each theme captures.
6. Lastly, the researcher should have a set of fully worked-out themes that involve the final analysis and write-up of the report. The task of the write-up of a thematic analysis is to tell the complicated story of the data in a way which convinces the reader of the merit and validity of the analysis. The analysis (the write-up including data extracts) should provide a concise, coherent, logical, non-repetitive, and interesting account of the story told by the data, within and across themes.

At the end of the thematic analysis phases, the researcher needs to raise important questions that would guide the analysis clearly. The sort of questions the researcher needs to be asking towards the end phases of his/her analysis include: What does this theme mean? What are the assumptions underpinning it? What are the implications of this theme? What conditions are likely to have given rise to it? Why do people talk about this thing in this way (as opposed to other ways)? What is the overall story revealed by the different themes of the topic? These questions should guide the analysis once the researcher has a clear sense of his/her thematic map (Braun & Clarke 2006:79). In this study, identifying important themes and sub-themes related to the study was crucial to facilitate the data analysis. A theme is something which captures the key idea about the data in relation to the research

questions and which represents some level of patterned response or meaning within the data set (Braun & Clarke 2006:82). The main requirement is to be consistent throughout the process of determining themes. As Braun and Clarke (2006) explain: themes or patterns within data can be identified either in an inductive “bottom-up” way, or in a theoretical deductive “top-down” way. The primary purpose of the inductive approach is to allow research findings to emerge from the frequent, dominant, or significant themes inherent in the raw data, without the restraints imposed by structure. The main purpose for using an inductive approach is to condense extensive and varied raw text data into a summary format, to establish clear links between the research objectives and the summary findings derived from the raw data, and to develop a model or theory about the underlying structure of experiences or processes which are evident in the raw data.

This study used important procedures to reduce the qualitative texts (Mayring 2002). In the case of the in-depth interviews and focus group interviews, the text units were progressively reduced in two or three rounds of sequential paraphrasing. First, the whole passage or paragraph was paraphrased into summary sentences. These sentences were further paraphrased into a few keywords (Jovchelovitch& Bauer 2000; Bauer 1996). Both reductions led to the generalisation and condensation of meaning. The text was arranged in three columns: the first column contained the transcript, the second column contained the first reduction, and the third column only contained keywords (Jovchelovitch & Bauer 2000; Bauer 1996). From paraphrasing, a category system was developed from which all texts were ultimately coded. First, categories were developed for each interview which was later gathered into a coherent overall category system for all interviews. A final category system could be structured through iterating revisions (Jovchelovitch & Bauer 2000; Bauer 1996). The final product constituted an interpretation of the data, combining relevant structures of the informants and of the interviewer.

The combination of the perspective of the researcher and the participants was significant for a qualitative analysis (Jovchelovitch & Bauer 2000; Bauer 1996). The researcher used a non-chronological order of story analysis because chronology was not a factor. The non-chronological aspects correspond to explanations and reasons found behind the events, criteria involved in the selections made throughout the story, and values and judgments attached to the story (Jovchelovitch & Bauer 2000; Bauer 1996). The story was organised to facilitate the understanding of the meanings in the context of the study. The researcher considered not only how the events were described, but also the network of relationships and meanings (Jovchelovitch & Bauer 2000; Bauer 1996).

5.14 VALIDITY AND RELAIBILITY

A researcher should ensure the overall trustworthiness of the research undertakings (Noble & Smith 2015). Trustworthiness of research data is associated with reliability and/or validity. Yin (2014:45) stated that to validate empirical research, a researcher should consider important criteria. The criterion includes construct validity, internal validity, external validity, and reliability. Accordingly, the researcher adhered to the construct validity, external validity, and reliability criteria. Yin (2014) stated that construct validity is about identifying correct operational measures for the concepts being studied. Construct validity is applied to the case study to reduce subjectivity. To do so, multiple sources of data such as in-depth interviews, focus group interviews, and document analysis were used during the data collection stages. Internal validity was not a factor in this case study research since the case study was not focused on explanatory or causal research (Yin 20). This means ensuring internal validity was not applicable to this study as the central aim of the research was not to identify cause-and-effect relationships between two or more variables. In addition, ensuring external validity was not the aim of this study. This is because the findings of this study were not generalised to the areas outside of the study sites. This means that with a case study it is impossible to generalise the results to the population outside of the contexts of the study. This study had no intention of generalising the findings. Instead, the sample was selected to understand the socio-cultural appropriateness of HIV/AIDS communication among the Borana pastoralist community as opposed to generalising the findings obtained to the entire pastoralists and/or non-pastoralist community in Ethiopia. Data interpretation plays a significant role in research validity. This means the findings should represent the reality (Lacey & Luff 2009).

Generally, in qualitative research unbiased data interpretation plays a significant role for research validity. Validity is judged by the extent to which an account seemed to fairly and accurately represent the data collected (Lacey & Luff 2009). The research design and approach for this study were appropriate for the research context. Adequate and systematic use of the original data, for example using quotation in the presentation of the analysis, was essential to ensure the validity. In such an analysis, the readers can be convinced of the interpretations relating to the data gathered (Lacey & Luff 2009). On the other hand, reliability of a research method is crucial to undertake a qualitative study (Lacey & Luff 2009).

The researcher should ensure that the methods used are reproducible and consistent.

However, unlike quantitative research, the external replications are not the most appropriate measure in a qualitative study (Lacey & Luff 2009). In this study, the researcher described the qualitative approach and procedures for data collection and analysis. The reliability of the qualitative study was assured by justifying the importance of using the qualitative methods. Furthermore, the reliability of the qualitative research was approved through clearly documenting the process of data collection, generating themes, analysis, and interpretation. Referring to external evidence, including previous studies, was essential to ensure reliability (Lacey & Luff 2009).

5.14.1 Validity and reliability as applied to the case study

Based on the studies by Yin (2014), Cresswell (2009), as well as Lacey and Luff (2009), the following mechanisms were used to ensure the validity and reliability in the context of this study.

- **Using relevant research methodology and research design:** suitable qualitative research methodology and case study design was used to undertake the study.
- **Applying an appropriate sampling technique and sample size:** a purposive sampling technique was used based on the nature of the study. The sample size was determined by the points of data saturation/theoretical saturation.
- **Using comprehensive and up-to-date literature:** the researcher reviewed current literature works to substantiate the study.
- **Applying diversified data collection techniques:** different data-gathering techniques such as in-depth interviews, focus group interviews, and document analysis were used to collect relevant data for triangulation.
- **Using an appropriate data analysis procedure:** a thematic data analysis procedure was applied to address the research objectives.
- **Substantiating the discussions with enough literature/theories:** the researcher reviewed adequate literature works to support the discussions with empirical evidence.
- **Developing a contextualised framework:** a conceptual framework which is suitable for the study population was developed as a contribution of the study.
- **Applying triangulation:** theoretical and data triangulation were used to validate the discussions.

5.15 TRIANGULATION

Triangulation is the use of multiple data sources and/or theories in qualitative research to develop a comprehensive understanding of a phenomenon (Kelle, Kühberger & Bernhard 2019). Triangulation has also been viewed as a qualitative research strategy to test validity through the convergence of information from different sources (Kelle, Kühberger & Bernhard 2019). This is a way of assuring the validity of the research using a variety of methods to collect data on the same topic, which involves different types of samples as well as methods of data collection. However, the purpose of triangulation is not necessarily to cross-validate data, but rather to capture different dimensions of the same phenomenon (Rutherford et al 2010).

Triangulation is a common feature in qualitative research (Leedy & Omrod 2006:100). Triangulating data gathered through different sources ensures data validity and reliability. It involved multiple qualitative approaches like in-depth interviews, FGIs, and document analysis. Data triangulation reduces personal bias and increases data verification when using multiple methods of data collection (Denzin 1989:236). This study applied triangulation for data validation. The data collected through FGIs, in-depth interviews, and document analysis was triangulated to complement each other based on the research objectives. The triangulation enabled the researcher to have a deeper and clearer understanding of the socio-cultural embedment of HIV/AIDS communication among the Borana pastoralist community in the Arero district. It also pointed out the gaps in HIV/AIDS communication and community practices concerning HIV/AIDS prevention. In addition, data triangulation enabled the researcher to confirm, elaborate, and shed light on the research tools (Marshall & Rossman 1995). Therefore, triangulation occurred at the final stage of data analysis and interpretation. All data collected through the different instruments were discussed separately. Then, the different data sets were triangulated at the interpretation stage to complement each other. The next section summarises the main points of this chapter.

5.16 CONCLUSION

This study used a qualitative research methodology, and case study research design was applied. The study was guided by a constructivism (interpretive) paradigm. The case study design was indispensable to get an in-depth understanding about the socio-cultural appropriateness of HIV/AIDS communication among the Borana pastoralist community in the

Arero district. The researcher was able to apply various data sources such as in-depth interviews, focus group interviews, and document analysis. The case study design assisted the researcher to make lively interactions with the study participants in their natural settings. A purposive sampling technique was used to recruit the study participants. The national HIV/AIDS policy of Ethiopia was analysed to compliment the primary data sources. The data gathered through FGIs, in-depth interviews, and document analysis was organised, analysed, and interpreted qualitatively, based on the notion of thematic data analysis. Data triangulation was used for data validation and complementation based on the research objectives. The findings of the in-depth interview data are presented in the next chapter.

CHAPTER 6
PART I: FINDINGS AND ANALYSIS OF THE IN-DEPTH INTERVIEW DATA

6.1 INTRODUCTION

The focus of this study was to assess the integration of HIV/AIDS communication with the socio-cultural domains in the Borana pastoralist community, Arero district, Borana Oromia, Ethiopia. Data from the in-depth interviews is presented in this chapter. The participants included cultural leaders, religious fathers, and healthcare workers. The in-depth interviews explored the lived experiences of the participants pertaining to the socio-cultural appropriateness of HIV/AIDS communication at the study site. To analyse the data, themes and sub-themes were developed and discussed in line with the research objectives. The selected qualitative research approach explores new areas where issues such as the socio-cultural integration of HIV/AIDS communication are not yet understood (Beverley et al 2009:4). Therefore, the data that was collected was analysed and discussed in three parts:

- Chapter 6 Part I: analysis of the in-depth interviews
- Chapter 7 Part II: analysis of the focus group interviews
- Chapter 8 Part III: document analysis

This chapter intended to answer the following research questions:

- *Does HIV/AIDS communication among the Borana pastoralists address the socio-cultural domains such as culture, religion/spirituality, and gender?*
- *What are the social behavioural change practices among the Borana pastoralists in relation to the community-based HIV/AIDS communication?*
- *What is considered acceptable and culturally appropriate HIV/AIDS communication approaches for the Borana pastoralist community?*

The findings were corroborated and any weaknesses in the data were compensated for by the strength of other data, thereby increasing the validity and reliability of the results (Denzin & Lincoln 2008). This study also used the notion of theoretical triangulation as different theories were used in the literature to move the study forward. Theoretical triangulation was helpful to capture the complexity of real-world phenomena concerning the participants' experiences of the community-based HIV/AIDS communication.

The use of a variety of data sources, theories, and methodologies gave adequate insight into the research problem (Denzin & Lincoln 2008). The data collected through in-depth interviews, focus group interviews, and document analysis was triangulated to complement each other. The data triangulation was crucial to validate and ensure the reliability of data sources (Babbie & Mouton 2001:97).

6.2 BIOGRAPHICAL DETAILS OF THE PARTICIPANTS

No	**Name of the participants (Pseudonyms)**	**Age**	**Social/professional responsibility**	**Place of residence (in the Arero district of Borana)**
1	Guyo Liban	78	Cultural leader	Mata Gafarsa *kebele*
2	Dugassa Beka	74	Cultural leader	Mata Gafarsa *kebele*
3	Jaldesso Wayu	62	Cultural leader	Haro Dimtu *kebele*
4	Boku Liban	66	Cultural leader	Renji *kebele*
5	Kayo Alake	64	Cultural leader	Guto *kebele*
6	Doyo Waritu	60	Cultural leader	Guto *kebele*
7	Tura kurkura	49	Cultural leader	Renji *kebele*
8	Abdi Tolcha	42	Cultural leader	Haro Dimtu *kebele*
9	Guyo Wako	68	Religious father (*Waaqeffataa* sector)	Renji *kebele*
10	Hassan Ahmad	58	Religious father (Islamic sector)	Haro Dimtu *kebele*
11	Abdi Tusa	48	Religious father (Protestant sector)	Mata Gafarsa *kebele*
12	Geebyehu Fekadu	55	Religious father (Orthodox sector)	Mata Gafarsa *kebele*
13	Biftu Badhane	38	Healthcare worker	Mata Gafarsa *kebele*
14	Tefera Gemeda	42	Healthcare worker	Guto *kebele*
15	Liban Waqo	48	Healthcare worker	Mata Gafarsa *kebele*

Table 6.4: Biographical information of in-depth interview participants

6.2.1 Cultural leaders

Cultural leaders (elders) who had social responsibility in the Arero district participated in the in-depth interviews. Eight cultural leaders participated in the in-depth interviews. A cultural leader (*Gadaa* leader) is expected to be male in Borana; all the research participants of the in-depth interviews were male. The age of the cultural leaders ranged from 42–70 years old. Furthermore, the researcher was unable to contact greater numbers of cultural leaders due to the outbreak of Covid-19. The cultural leaders had an in-depth understanding related to the Borana cultural issues regarding the appropriateness of HIV and AIDS communication. For example, the cultural leaders have a good understanding of the cultural institutions like *Gadaa* and its role in the different social, economic, and political affairs of the Borana people. The socio-cultural data such as culture, religion/spirituality, gender, and communication contexts related to HIV/AIDS were collected from the cultural leaders using the storytelling technique.

6.2.2 Religious fathers

Four religious fathers, serving in the congregations and/or lead religious institutions participated in the in-depth interviews. The religious fathers selected were between 48–68 years of age and were selected from four religions: Islam, Protestant, Orthodox, and *Waaqeffataa*. Accordingly, one participant was selected from each religion. The number of religious fathers was limited because of availability as well as the outbreak of Covid-19. The research participants provided in-depth data concerning HIV/AIDS communication, especially from the religious/spiritual perspectives. The in-depth interviews were conducted in a natural setting, in the district of the residents. The data was collected between 15 December 2020 and 17 December 2020 using pen-and-paper interviews; some of the in-depth interview data were taken in the form of short notes during fieldwork.

6.2.3 Healthcare workers

Healthcare workers who had HIV/AIDS communication experience at the study site participated in the in-depth interviews. Two of the healthcare workers were men while one was a woman between 39–48 years. The number of the healthcare workers was limited because the researcher could not access more participants due to the outbreak of Covid-19 and the restriction it put on face-to-face interpersonal communications placed by the

government. The participants provided in-depth data, especially from the health profession's point of view. The in-depth interviews were conducted in a natural setting, in the district of the residents. The data was collected between 18 December 2020 and 19 December 2020 using pen-and-paper interviews; some of the in-depth interview data were taken in the form of short notes.

6.3 IN-DEPTH INTERVIEW DATA ORGANISATION

Audio recordings during the in-depth interviews were not consistent due to expressed discomfort by some of the study participants and the challenges imposed by Covid-19. Two individuals who had good knowledge of the Borana dialect and the pastoralist community were recommended by the local administrations to assist the researcher in facilitating and arranging an interview schedule as well as clarifying some of the unfamiliar Borana dialect during the interviews. The research facilitators and the researcher took notes during the interviews that were later elaborated into field notes. The field notes were translated into English and then translated into Afan Oromo to ensure the validity of translations.

6.4 THE SOCIO-CULTURAL DIMENSION OF HIV/AIDS COMMUNICATION

This study is based on the socio-cultural approach to HIV/AIDS communication. As a result, the study was based on health behavioural models, theories, and concepts that have socio-cultural relevance in the context of the Borana pastoralists. Themes and sub-themes of this section focused on tailoring HIV/AIDS communication to the socio-cultural domains namely: the environmental context, culture, social values and norms, oral traditions, language, symbols, cultural institutions, social networks and associations, marriage, and Indigenous knowledge system and practices. These elements of the socio-cultural contexts are discussed as the chapter precedes though different themes and sub-themes which emerged from the data analysis process. Therefore, the data related to the socio-cultural context of HIV/AIDS communication among the Borana pastoralist community was imperative to the study.

6.4.1 Pastoralist environment hampering effective HIV/AIDS communication

HIV/AIDS campaigns have been under way in the Borana pastoralist community for more than three decades. However, the pastoralist community in Borana, Ethiopia, is among the underprivileged population groups in gaining access to adequate and contextualised health services (Kaba, Ame & Mariam 2013). After a remarkable decline, HIV infections started to increase again in the last few years in Ethiopia (Girum et al 2018). The existing evidence shows that the disease is re-emerging in Ethiopia (Girum et al 2018). This study reveals that HIV/AIDS campaigns among the Borana pastoralist have its own gaps (Serbessa 2019). Geographically, Borana pastoralists reside in arid areas of the southern part of Ethiopia. Borana borders on Somalia to the east and Kenya to the south (Serbessa 2019). Characteristically, livestock rearing is the major economic foundation in Borana (Serbessa 2019). Livestock production is culturally embedded into the structure and function of the rangeland system. Pastoralist families traditionally rely on livestock products. The people of Borana share common social and cultural features. The pastoralist community is known for its Indigenous socio-cultural values (Serbessa et al 2016). The Borana pastoralist community has its own approach to communication that is linked to the socio-cultural context. HIV/AIDS communication and the campaign strategies are therefore expected to consider the features of pastoralist ecology, deep-rooted socio-cultural issues, and the pastoralist livelihoods. HIV/AIDS communication approaches should coincide with the context of the target audiences (Kloos et al 2013; Dugassa 2014; Aguilar 2009). The existing data reveals that HIV/AIDS communication was not adequately twined with the reality of the pastoralist context. In line with this, the in-depth interview participants, Guyyo Liban and Dugassa Beka, said that:

> *HIV/AIDS communication does not consider the environmental situations of the pastoralists. The communication approach does not consider the mobile nature of the pastoralists (people moving with livestock in search of water and pasture). HIV/AIDS campaigns are more limited to the urban corridors and rural health stations* (Guyyo Liban_Mata Gafarsa kebele).

> *The government allocates desert allowance for health professionals. However, the professionals are not interested in living in the drought-prone areas. There is a high worker turnover due to the climate problems. Health professionals prefer to reside in the urban areas. Health facilities are more adequate in the urban areas.*

HIV/AIDS communication did not adequately consider the pastoralist environment and livelihoods (Kayo Alake_Guto kebele).

Pastoralists live in the hottest areas. There is a lack of infrastructure such as roads, water, electricity, and health facilities. Health professionals prefer to reside in the urban areas during drought seasons (Dugassa Beka_Mata Gafarsa kebele).

This data reveals that the pastoral environment and harsh climatic conditions adversely affected HIV/AIDS communication. This agrees with Bastien et al (2011) who indicated that HIV/AIDS communication strategies in Africa are affected by ecological and contextual factors. Environmental challenges increase susceptibility to HIV infections and undermine the prevention efforts (Janet et al 2012). The data shows that the mobile nature of the pastoralists did not create a suitable situation for effective HIV/AIDS communication. This agrees with the study by Shira et al (2012) which stated that mobility, due to socio-economic impacts, exacerbates HIV risks and impedes the effort to prevent the epidemic. The data from the in-depth interviews indicated that poor infrastructure in the pastoralist community obscured effective HIV/AIDS campaign strategies. The multiple domain model states that socio-structural, socio-environmental, and situational/contextual factors potentially influence behaviour directly (Zimmerman, Christakis & Meltzoff 2007). It is possible to infer from the in-depth interviews that healthcare workers, who are unfamiliar with the pastoral culture and climatic conditions, face difficulty in addressing HIV/AIDS messages (Lieber et al 2021:66). Healthcare workers coming from another region than the pastoralist region could not withstand the harsh climate in the pastoral areas. Some healthcare workers preferred to leave the environment especially during long drought seasons. It is possible to deduce that the health system in the pastoralist area was not fit for the pastoralist context. One in-depth interview participant, Kayo Alake, explained the issue by saying:

I do not see my elder sons during the drought for months sometimes. The youth move long distances with livestock in search of water and pasture. Most of the time clashes occur over water and grazing land. The instability of healthcare workers and irregularity of health services due to the harsh climate hampers pastoralists' accessibility to health services. Healthcare workers could not withstand long droughts in the pastoralist community. The urban community is more privileged (Kayo Alake_Guto kebele).

The data confirmed that the lowlanders (pastoralists) were not accommodated in accessing contextualised HIV/AIDS messages. HIV/AIDS campaigns gave more attention to the urban areas where there are more favourable weather conditions and facilities. HIV/AIDS communication in Borana favours the permanent settlers of the highlands (Kaba 2013). The data indicated that drought season is one of the factors that hampered effective HIV/AIDS communication with the pastoralist community of Borana. The relationship between the pastoralists and the healthcare workers during drought seasons was too weak to undertake HIV/AIDS campaigns. Thus, there is a need to have pastoralist-friendly health system that can address the health problems of the pastoral community, regardless of the environmental strains and harsh climate. The PEN-3 cultural health model reveals that HIV/AIDS communication in the cultural communities of Africa needs to consider contexts such as the socio-demographical and environmental contexts (Iwelunmor, Newsome & Airhihenbuwa 2014; Cowdery, Parker & Thompson2010; Airhihenbuwa 2007a). In addition, the multiple domain model states that health communication, including HIV/AIDS, should consider the contextual factors in the community (Zimmerman, Christaki & Meltzoff 2007). The culture-centred approach to health communication calls for attention to dialogue and locates cultural participants in the culture to be studied (Basu & Dutta et al 2009). In line with the conceptual framework developed in Chapter 4, HIV/AIDS communication in Borana should consider the socio-cultural path of disease prevention strategies that consider the specific features of the Borana pastoralists.

6.4.2 Borana cultural institutions

Borana Indigenous institutions such as *Gadaa*, *Gumii Gaayyoo*, and *Qaalluu* play a significant role in the social, cultural, religious, economic, and political lives of the community. In addition, the *Odaa* tree is honoured symbolically as the most important of all trees among the Borana Oromo people. Socio-cultural, economical, and political activities such as cultural rituals, power transition, revising and enacting customary laws, and judiciary practices are usually held in the shade of an *Odaa*tree. In line with this, the participants, Boku Liban and Guyo Liban, reflected that:

> *The Odaa tree is a cultural symbol In Borana. The tree is revered. The Borana discusses important issues under the Odaa tree. Blessings are given under the Odaa tree. It is where the Borana solves any conflicts through discussions. However, HIV/AIDS communication is more limited to the office settings* (Boku Liban_Renji kebele).

> *The Odaa tree is where Borana cultural leaders give communal blessings. The Borana are interested in addressing different social, economic, and political issues in consultation with the Gadaa leaders under their symbolic tree. HIV/AIDS communication strategies did not consider the socio-cultural attachment of the Borana people to the Odaa tree* (Guyo Liban_Mata Gafarsa kebele).

The data confirms that HIV/AIDS communication in Borana did not consider the cultural significance of the *Odaa* tree in the community. The community-based HIV/AIDS communication overlooked the cultural role of the tree in promoting positive dialogue to curb the spread of HIV/AIDS. This agrees with Bassi and Tache (2007), who states that health interventions in Borana did not adequately consider the cultural resources. The Borana *Gadaa* system is used to play an important role in the social, economic, political, and spiritual lives of the Borana people. The *Gadaa* system was recorded by UNESCO in 2018 as an intangible cultural heritage, an Indigenous socio-cultural, economic, and political institution where the power is transferred democratically every eight years. Every public affair such as social, political, economic, ecological, and rituals are primarily regulated by the *Gadaa* institution (Edossa et al 2005). The Borana *Gadaa* leader commonly named, *Abbaa Gadaa* (*Gadaa's* father), holds the central power. Gada leader can be considered as Gada father in the context of Borana. In Borana, when passing through the Gada grade, the top three councillors of the generation-set assume the position of the "father of Gada," who has the highest authority in the Gada system. The Borana memorises the period when the "father of Gada" takes office as an era, and the name of the highest "father of Gada" becomes a reference (Legesse 1973). *Bokkuu* is the cultural term used for symbolic power. The *Gadaa* father is greatly respected among the Borana community (Legesse 1973). Healthcare workers need to use the Indigenous knowledge system and institutions for contextualised HIV/AIDS communication in Borana. However, the data shows that Indigenous cultural resources in Borana were not well utilised to curb the spread of HIV/AIDS. The participants, Boku Liban, Guyo Liban, and Abdi Tolcha, said that:

> *Gadaa is an iconic cultural symbol among the Oromo. Gadaa leaders are powerful in the community. The community trusts messages from the Gadaa leaders. The cultural resources are not adequately utilised* (Boku Liban_Renji kebele).

> *Gadaa regulates the socio-cultural, economic, and political activities in Borana. It enforces moral conduct and builds social cohesion. Gadaa also expresses forms of*

community culture. The Borana life philosophy is attached to the Gadaa system. However, the health system is not well integrated with the notion of the Gadaa system. Gadaa is people centric. The communication approach in the Gadaa system is two-way and bottom-up. HIV/AIDS communication is more top-down and expert-oriented (Guyo Liban_Mata Gafarsa kebele).

The Gadaa cultural institution is the symbol of peace. In the Gadaa system, Oromo has different customary laws such as the law for the land, the law for the tree, the law for children, the law for women, and the law for cattle. A malpractice in the community is seen in terms of the customary laws. Healthcare workers are expected to use this cultural institution to change the behaviour of the society concerning HIV/AIDS (Abdi Tolcha_Haro Dimtu kebele).

When evaluating the PEN-3 cultural model for Africa, culture is at the centre of promoting societal health (Cowdery, Parker & Thompson 2010). Culture should be viewed for its strength and not always as a barrier (Iwelunmor et al 2014). The multiple domain models also assert that socio-structural, socio-environmental, and situational/contextual factors potentially influence behaviour directly (Zimmerman, Christakis & Meltzoff 2007). Engaging culture and cultural resources to promote societal health is a dimension of participatory approaches that genuinely begin where people are and work to address aspects of their life that they identify as important health issues (Okechi 2018). The study by Khandu, Tobgay & McFarland (2021) also underscores that social and cultural values, norms, and traditions influence individual lifestyles and behaviours (Khandu, Tobgay & McFarland 2021). In line with this, the participants, Guyo Liban and Doyo Waritu, pointed out that:

Gumii Gaayyoo (cultural assembly of multitudes) is an assembly by the Borana people every eight years. Decisions at the GumiiGaayyoo are expected to guide the lives of the Borana people, including marriage. For instance, GumiiGaayyoo acknowledges marriage to more than one wife. However, Gumii Gaayyoo as a cultural opportunity was not well utilised by the health institutions. The relationship between healthcare workers and cultural leaders to enforce cultural laws and regulations pertaining to HIV/AIDS campaigns was superficial (Guyo Liban_Mata Gafarsa kebele).

In Borana, Gumii Gaayyoo is a cultural assembly where laws are amended and/or made. A Gadaa leader who completes his term (eight years) also transfers power

during GumiiGaayyoo. Decisions at the GumiiGaayyyoo guide the lives of the Borana people. GumiiGaayyoo socio-cultural opportunities are not well utilised by the health institutions. A GumiiGaayyoo decision concerning HIV/AIDS is not strong. The relationship between HIV/AIDS programme planners and the cultural leaders is not strong (DoyoWaritu_Guto kebele).

The data affirms that the *GumiiGaayyoo* cultural assembly was not effectively used to communicate HIV/AIDS messages. The *Gumii Gaayyoo* assembly passed the decree that Borana men can marry multiple women, based on the size of the property a man has. Ahinkorah et al (2020) stated that the desire for more children in Africa is driven by the preference for large families, a desire for sons, the union's stability, and preserving a place of residence and land. Morgan-Fleming, Riegle & Fryer (2007) also reported that there is a perception in Africa that the government population control programme seeks to limit the number of children that women may have to reduce the population growth rate in Africa. The decree that promotes polygamy indicated that there has been loose coordination between healthcare workers and cultural leaders. The cultural decision that supports polygamy, in one way or another would aggravate the problems of HIV/AIDS. This implies that the health communication did not challenge the cultural practices and decisions that encourage polygamy and/or extramarital sexual intercourse. It agrees with the findings of Rogers et al (2021) that states that the development communication, such as health in the pastoral society of Africa, relied on a simplistic approach that overlooked the complexity of overlapping, and often contradicting, issues in the cultural community.

In line with the PEN-3 cultural model, HIV/AIDS communication with Borana pastoralists needs to utilise the positive cultural resources to curb the spread of the epidemic (Airhihenbuwa, Ford, &Iwelunmor 2014). Health information, education, and communication should be committed to promoting health and preventing disease by utilising the Indigenous cultural resources such as the *GumiiGaayyoo* cultural institution (Thiabaud et al 2020). In addition, the multiple domain model states that health communication, including HIV/AIDS communication, should consider the contextual factors in the community (Zimmerman et al 2007).The culture-centred approach to health communication calls for attention to dialogue and locates cultural participants in the culture being studied (Ambar et al 2009). Furthermore, in line with the conceptual framework developed in Chapter 4, HIV/AIDS communication in Borana should consider the socio-cultural path of disease prevention strategies that consider the specific features of the Borana pastoralists.

6.4.3 The role of Borana social networks to curb the spread of HIV/AIDS

Social networks are a set by connections, which are used to bring the community together to accomplish different goals such as economic, social, and political issues. In developing regions, such as sub-Saharan Africa, social networks play crucial roles in assisting the day-to-day lives of people in the society. The PEN-3 cultural health model for Africa states that HIV/AIDS communication needs to utilise the positive socio-cultural resources in the local areas to curb the spread of the epidemic (Airhihenbuwa, Ford & Iwelunmore 2014). There is a need to consider a culture-centred approach to HIV/AIDS communication that focuses on the Indigenous resources, like social networks, to prevent the spread of HIV/AIDS. Accordingly, the Borana pastoralist community in the Arero district has different cultural associations and social networks through which the people address problems and challenges. In the Borana pastoralist community there are different social networks such as *Buusaa*, *Gonofaa* social networks, and *Marroo* that support the day-to-day life of the local community during hard times. The participants, Abdi Tolcha and Doyo Waritu, explained:

> *The Borana has the Buusaa traditional system. Buusaa means contribution. Busaa is an early warning system in Borana that triggers a traditional support mechanism. People voluntarily contribute money and other things (such as crops) to support a clan, individual, or members of a family to withstand shocks such as drought. Through Buusaa social protection networks, people come together to discuss social problems and other related issues of Borana. The Buusaa social network was not well utilised to support HIV/AIDS communication* (Abdi Tolcha_Haro Dimtu kebele).

> *Gonofaa is among the social protection networks in Borana. Gonofaa is an obligatory contribution. Individuals and families facing challenges get support through the Gonofaa social protection network. Every member of the community has the obligation to participate in Gonofaa to save the lives of community members or families who may be in serious situations. Health workers fail to consider the role of such social gatherings to address HIV/AIDS messages* (Doyo Waritu_Guto kebele).

The feedback indicated that the already existing social networks in the community were not properly utilised in communicating HIV/AIDS messages to the wider community. The health communication overlooked the Indigenous system of social interaction that would help to address health messages. Social networks play a critical role in health communication among the pastoral community in Africa (Khandu, Tobgay & McFarland 2021). Borana has

informal social networks of support named *Marroo*. *Marroo* social networks help women (mothers) to support each other in a time of difficulty. The Indigenous system that binds the local community was not properly used in promoting societal health, including HIV/AIDS. The participant, Jaldesso Wayu, reported:

> *Borana women have informal social networks called Marroo. Marroo means maruu (encircle or make round) in which the members of the social networks get support in turns during tough times. Marroo is a social institution where Borana women come together to withstand problems in the times of difficulty. Utilising Marroo social networks for HIV/AIDS prevention is not common* (Jaldesso Wayu_Haro Dimtu Kebele).

This implies that HIV/AIDS message designers did not properly look at the available social networks such as *Buusaa*, *Gonofaa*, and *Marroo* to effectively address HIV/AIDS messages. The HIV/AIDS messaging system in the Borana pastoralist community should place emphasis on the already existing social networks (linkages) to reach the wider pastoralists with a user-friendly approach.

6.4.4 Using Borana folk traditions to convey HIV/AIDS messages

Borana pastoralists are well known for their Indigenous cultural resources such as folklore or folk traditions. Folk media or folk traditions help to address local interests and concerns (Ochs et al 2001). The Borana pastoralist community is more for orality. History, belief systems, value traditions, and norms of the Borana are transferred from generation to generation through folk traditions or orally (Legesse 1973). This indicates that health communication, including HIV/AIDS messaging, should consider the oral culture of the Borana pastoralist for effective messaging. In relation to this point, the participants, Kayo Alake and Doyo Waritu, explained:

> *Borana is rich in oral traditions. We are proud of our folk traditions. The Borana pastoralists have profound interest in their oral traditions/cultural conversations. The HIV/AIDS communication lacks such cultural aspects* (Kayo Alake_Guto kebele).

> *Fables are common in Borana culture. Elders deliver moral messages to people through fables. Oral fables are more touching to teach good behaviour. Health*

institutions are not using Borana folk traditions, such as fables, to teach about HIV/AIDS (Doyo Waritu_Guto kebele).

The data shows that HIV/AIDS messages did not consider the use of oral traditions to communicate HIV/AIDS. Folk media in the community, which are oral in nature, were not properly integrated or linked into the HIV/AIDS communication. The HIV/AIDS messaging system was more professional and formal, which overlooked the informal, important folk media, which has cultural ingredients. Therefore, there is a need to integrate HIV/AIDS messaging into the suitable folk media of the community for effective communication. This would help to contextualise HIV/AIDS messages using the available oral medium of communication. The multiple domain model states that socio-structural, socio-environmental, and situational/contextual factors could potentially influence behaviour directly (Zimmerman, Christakis & Meltzoff 2007). The multiple domain models consider the influence of the contextual domains in changing health behaviour. The PEN-3 cultural model for Africa also states that health communication in Africa should consider the Indigenous contexts such as African traditional values, norms, belief systems, and languages (Airhihenbuwa 2007a). Furthermore, in line with the conceptual framework developed in Chapter 4, HIV/AIDS communication in Borana should consider the socio-cultural path of disease prevention strategies that consider the specific features of the Borana pastoralists.

The African health communication approach, which is influenced by western health communication theories and models, has overlooked the home-grown forms of communication such as folk media or folk traditions (Thiabaud et al 2020; Cowdery, Parker & Thompson 2011:26; Airhihenbuwa 2007a). ThePEN-3 cultural model provides valuable guidelines. Health intervention in Africa should be culturally specific and suit the African context (Airhihenbuwa 2007a). Healthcare workers in Africa are influenced by the western mode of health communication. The effort to use the Indigenous knowledge system to prevent and/or communicate health issues is inadequate in Africa. In addition, health communication in Africa focuses on the medical aspects of disease prevention and overlooks the arts and behavioural aspects. In relation to this, the participants, Abdi Tolcha and Boku Liban, said that:

Health professionals depend on scientific knowledge and formal communication. The focus is more on the content of health communication. The means of communication seemed to be overlooked. I think if health workers use colourful, but familiar, oral

stories to teach about HIV/AIDS, the pastoral community would be happier (Abdi Tolcha_HaroDimtu kebele).

Cultural drama can help to catch up with the intended HIV/AIDS message. People can easily understand an HIV/AIDS message if the message is supported by a stage performance that uses the local cultural elements such as songs and dance. However, HIV/AIDS campaigns don't use it. Healthcare workers as well as NGOs focused on the usual way of informing, educating, and communicating about HIV/AIDS. The cultural lens of HIV/AIDS campaigns requires more attention (Boku Liban_Renji kebele).

The data affirms that HIV/AIDS messaging in the Borana pastoralist community focused more on the medical aspects. The social and behavioural sciences of disease prevention such as cultural contexts, arts, and oral stories were unnoticed. The data further indicated that the art of communicating HIV/AIDS messages using folk media and oral stories was undermined at the site. HIV/AIDS is both a biomedical disease and a social phenomenon that is constructed in specific cultural contexts (Thiabaud et al 2020; Mabweazara, Ley & Leach 2018). The data shows that cultural performances such as drama (theatrical arts) that can help to communicate HIV/AIDS in the cultural society, was not effectively used with the Borana pastoralists.

Valente and Bharath (1999) reported that drama can be an effective medium for communicating HIV/AIDS information and can reduce knowledge gaps associated with low levels of formal education. Dramatic performances could be structured to be a purposeful, goal-directed, and intentional activity, which is entertaining, educative and could be healing. It is referred to as a "face-to-face", non-mediated relationship between (or among) any number of participants that has the power of engagement during message communication (Bamidele et al 2017). There is a need for better integration by the contributions of the social and behavioural sciences to improve access to health-related services (Vermund & Hayes 2013). Therefore, HIV/AIDS communication in the Borana pastoralist community should consider the available cultural opportunities, such as the use of contextualised drama to address HIV/AIDS messages.

As an element of folk traditions in Africa, proverbs are tools to maintain healthy coexistence as well as a way of transmitting knowledge and wisdom among the Oromo (Biratu & Kosa 2020). Proverbs are an integral part of the Borana Oromo culture, handing down and

imparting norms, values, rules, and the worldview of the community to guide people (Biratu & Kosa 2020). Proverbs and proverbial expressions have an active role in managing the interactions of people during communication (Adesina & Akala 2015). This implies that proverbs have the power to grab the attention of the audiences for effective communication, including health communication. The Borana are rich in proverbs; the people are wise to tell oral stories using proverbs to convey messages regarding any affairs of the community.
In line with this, the participants, Abdi Tolcha, Kayo Alake, and Guyo Liban, explained the proverbs of Borana by saying:

> *Borana pastoralists use proverbs to summarise a complex agenda. Proverbs can easily untie complex social dialogue. In Borana, it is said: "Ittoon soogidda hinqabneefi dubbiin makmaaksa hinqabne hinminyaa'u." This means: "Curry without salt, speech without proverb is bitter." "Jabbiin korma fakkaatti, mammaaksi dubbiin fakkaatti." This means: "Calf resembles the bull; and proverbs resemble the themes." Health workers are not familiar with the Indigenous Borana proverbs to communicate about HIV/AIDS. Oral cultures, such as proverbs, are not adequately used in HIV/AIDS communication* (Abdi Tolcha_Haro Dimtu kebele).

> *Borana proverbs give life to the local conversations. The Borana knows how to make conversations simple, yet more touching and attractive by using proverbs and riddles. Our culture, such as proverbs and riddles, were not adequately utilised in the health development of the pastoral community. HIV/AIDS communication materials lack the Borana cultural flavour* (Kayo Alake_Guto kebele).

> *Borana proverbs have the power of alerting people about a problem. The proverbs tell people to get prepared before it is too late. For instance, Borana says "Ganna darbe mana hinijaarani." This means: "A house cannot be built for last summer." This proverb is about foolish preparation. The Borana oral traditions were not effectively used in the HIV/AIDS communication (*Guyo Liban_Mata Gafarsa kebele).

The feedback confirmed that healthcare workers in the Borana pastoralist community failed to integrate Borana oral traditions and folklore, such as proverbs and riddles, into the community-based HIV/AIDS messaging. The study by Adegoju (2009) reported that proverbs contain traditional observations that serve to guide people in their day-to-day activities. The study by Sonke et al (2018) also suggested that arts humanise, clarify, and empower health communication. Therefore, HIV/AIDS communication within the Borana

pastoralist community should consider the locally available art of communication such as proverbs, riddles, and cultural songs to address clear, meaningful, and compelling HIV/AIDS messages. The values of Indigenous communication initiatives that emerge spontaneously from communities (instead of those strategically engineered from outside the general population) should be considered as a future direction of HIV/AIDS communication in developing regions like sub-Saharan Africa (Bekalu & Eggermont 2014; Yoshida et al 2012). This implies an oral channel of HIV/AIDS communication in sub-Saharan Africa that is rooted in the local tradition plays a significant role to curb the spread of the epidemic (Yoshida et al 2012). It aligns with the notion of the PEN-3 cultural model for Africa which argues that health communication approaches in Africa should be Afro centric and consider the socio-cultural value of the target population (Airhihenbuwa 2007a).

6.4.5 Borana marriage culture and sexual relations

Health communication is taken into consideration along with the culture of the target community that contributes positively or negatively to the health of the society (Foege 2010). Healthcare workers need to consider the deeply rooted culture, such as marriage culture, for effective health communication including HIV/AIDS. The mechanisms of health communication should be intergraded into the local contexts (Kaba 2012). In line with this, the participants, Dugassa Beka and Boku Liban, said:

> *Mothers are responsible to counsel girls about marriage in Borana. Fathers are responsible to counsel boys. Couples are not expected to have any sexual intercourse prior to marriage. Healthcare workers in the community are reluctant to promote and sustain good marriage culture* (Dugassa Beka_Mata Gafarsa kebele).

> *Sex before marriage is taboo in Borana. Someone who engages in sexual intercourse before marriage is locally called "cabana" which means "out casted." A pregnant Borana girl has no moral right to stay with her family and clan. Once a Borana girl is impregnated without formal marriage, she will be out casted* (Boku Liban_Renji kebele).

The feedback confirms that Borana marriage culture play a significant role to discourage sex before marriage. Marriages arranged by the families in Borana play a positive role to avoid early sexual intercourse that exposes people to the problems of HIV/AIDS. However, the data confirms that there was less coordination between healthcare workers and the local

community in promoting the positive aspect of cultural marriages that would help to curb the spread of HIV/AIDS. It is plausible to infer that the cultural marriages overlooked testing for HIV/AIDS.

Healthcare workers under the Borana pastoralists should identify the positive and negative aspects of cultural marriages and address HIV/AIDS messages accordingly. Social media allows for connection with more people; it is possible to be influenced by views of others when in a comprehensive situation. Some people do not have control over what to share on their social sites (Holt, Smith & Layton 2010). In addition, Cohen and Farley (2004) posits that the habit of going on social media after a disagreement is quite common in marriages today, leading to marital discord. Emerging technologies, such as social media, continue to hamper marriage culture. Social media threatens the good marriage culture and sexual norms (Cohen & Farley 2004). The participants, Tura Kurkura and Doyo Waritu, elaborated on the situation by saying:

> *Technology challenged our "assumed to be a good" marriage culture. Young people are exposed to different sex videos and films* (Tura Kurkura_Renji kebele).

> *Mobile technology (social media) initiates untimely sexual intercourse. Technology has been threatening the valuable marriage culture. The youth are pressured to engage in sexual intercourse before marriage* (Doyo Waritu_Guto kebele).

The data confirms that the use of emerging technology, such as social media, has been challenging the Borana marriage culture. Sexual information disseminated through sex videos and sexual messages on mobile phones has the power to challenge good marriage culture that prohibits sex before marriage. This agrees with Njue et al (2011) who reported that watching sex videos on a mobile device and/or the media might initiate untimely sexual intercourse. Sex videos such as pornography contributes to forced sex, gang rape, and multiple concurrent relationships that characterise the sexual encounters of youth, frequently facilitated by the abuse of alcohol (Njue et al 2011). The multiple domain models discussed in Chapter 3, Part II, and the conceptual framework presented in Chapter 4 asserts that HIV/AIDS communication in the cultural community needs to consider the contextual domains like the marriage culture.

6.4.5.1 Polygamy

Polygamy as an institution is less of a concern in sub-Saharan Africa(Damtie et al 2021; UNAIDS 2020; Lawson & Gibson 2018; Mwambene 2017).People who are in polygamous relationships are more likely to engage in extramarital sex (Damtie et al 2021; Gazimbi et al 2020; Bajunirwe et al 2019).Polygamy increases the spread of HIV/AIDS and other sexually transmitted diseases (STDs) (Bajunirwe et al 2019; Lawson & Gibson 2018; Reniers &Tfaily 2012; Eaton, Hallett & Garnett 2011).Polygamy is legally prohibited in Ethiopia (Damtie et al 2021). It undermines women's self-worth, violates gender equality, and women's rights (Damtie et al 2021). Polygamy has the potential to increase the spread of HIV/AIDS and other STDs (Reniers &Tfaily 2012; Eaton, Hallet & Garnett 2011; Halperin & Epstein 2004). However, it is accepted by the Borana cultural assembly of the multitudes (*Gumii Gaayyoo*). As a result, polygamy is practised in the Borana pastoralist community regardless of its effect on the spread of HIV/AIDS. The participants, Guyo Liban, Jaldesso Wayu, Boku Liban, and Tura Kurkura, explained this issue by saying:

> *HIV/AIDS has not been well articulated during the GumiiGaayyoo cultural assembly in the past. Nowadays, HIV/AIDS receives less attention because of Corona* (Guyo Liban_Mata Gafarsa kebele).

> *Borana men can have multiple wives. What limits the number of wives among the Borana men is not the government system, but the resources a man has. In the pastoralist community, males have the right to have multiple wives. The pastoralists have many resources such as land and livestock. There is a need to give birth to numerous children to secure the land resource for the generations to come. For instance, I have a plan to marry a new wife next month. I need to have more than twenty children. I have the resources. I have no problem to manage my family. The family planning issues does not work. Our culture and the pastoralist reality on the ground force us to have many wives* (Jaldesso Wayu_Haro Dimtu kebele).

> *Borana has adequate land and livestock. Borana pastoralists reside at the border of the country. There are enemies who grab the pastoralists' land resources. The Borana needs to have more children to protect their land and resources. The Borana needs to have more wives. The Gumii Gaayyoo decision that supports polygamy is acceptable to God* (Boku Liban Renji kebele).

> *Borana men need to have multiple wives. The Borana culture allows us to marry more girls, even virgins. We have considerable numbers of cattle: goats, camels, sheep, and donkeys. One wife cannot manage all of these. One wife may give birth to not more than five children on average. This is less for us. I am happy to have many wives* (Tura Kurkura_Renji kebele).

The feedback affirms that polygamy has the cultural recognition in the Borana pastoralist community. The data shows that polygamy was practised to have a greater number of children and own more resources such as land and cattle. The data further asserted that there was a weak relationship between the health institutions and cultural institutions in the Borana pastoralist community to manage HIV/AIDS exacerbating factors such as polygamy. The practice of polygamy in the Borana pastoralist community did not consider the issues of HIV/AIDS. Concurrent partnerships are powerful transmitters of HIV in the traditional African community (Mah & Halperin 2010). Regardless of its effect on the spread of HIV/AIDS, polygamy is encouraged among the Borana pastoralists to have a greater number of children to control the land resources. Polygamy as a sexual union is believed to increase the number of children per household as well as the possibility of wealth accumulation (Gazimbi et al 2020). Healthcare workers should work with the cultural leaders to challenge the practices of polygamy that exacerbate the spread of HIV/AIDS. A cultural approach offers a chance to improve the effectiveness of HIV/AIDS communication and rebuild the trust of communities through more sensitive modes of engagement (Uwah 2013).As discussed in Chapter 3, Part II, health models and theories such as the PEN-3 cultural model, the multiple domain level and the conceptual framework developed in Chapter 4affirm that HIV/AIDS communication in Borana should consider the traditional factors that contribute to the spread of the epidemic. A socio-cultural approach to HIV/AIDS prevention helps to design culturally suitable messages that help to effectively curb the spread of the epidemic (Iwelunmor, Newsome &Airhihenbuwa 2014; Airhihenbuwa 2007a; Zimmerman, Christakis & Meltzoff 2007). In the context of HIV/AIDS communication in Borana, the relationship between polygamous sexual relations and HIV risk should be considered and addressed from the socio-cultural perspectives (Shih et al 2017). Additionally, in line with the conceptual framework developed in Chapter 4, HIV/AIDS communication in Borana should consider the socio-cultural path of disease prevention strategies that consider the specific features of the Borana pastoralists.

6.4.5.2 Widow inheritance

Widow inheritance is a widespread cultural practice in sub-Saharan Africa that has been identified as a contributing factor to the risk of HIV transmission (Agot et al 2010). Perry et al (2014) indicated that widow inheritance usually helps to maintain the social and economic welfare of widows and orphans (Sovran 2013). The widow can marry someone from the clan as the culture dictates (Agot et al 2010). Widow inheritance has been implicated in the spread of HIV/AIDS because it encourages the formation of extended sexual networks (Sovran 2013). The participants, Doyo Waritu and Tura kurkura, further explained the problem of widow inheritance and extramarital sexual intercourse:

> *A wife belongs to the clan. The youth belongs to the clan. Land belongs to the clan. A Borana wife, whose husband passed away, is expected to stay within the clan and bring up her children. She can give birth. The clan has the responsibility to look after the children. A Borana man has the right to decide whom and how many to marry. Decisions on resources and sexual issues are mostly made by the man (husband)* (Doyo Waritu_Guto kebele).

> *Dhaala (widow inheritance) is within Borana marriage culture. Dhaala is a marriage usually between a woman and a brother of a deceased husband. The wife of the deceased husband remains within the clan via such marriage. It is to preserve the resources such as land and livestock of the deceased husband. It allows children of the deceased husband to grow up within their clan. But there is no test for HIV/AIDS in such cultural marriages of Dhaala* (Boku Liban_Renji kebele).

> *There is less control regarding widow inheritance among the community. Most pastoralist women are obedient to the decisions of their husbands. The husband has the right to decide whom and how many women to marry. When a wife is mistreated, she can appeal to the cultural leaders. Decisions on resources and sexual issues are made by the husband* (Tura kurkura_Renji kebele).

It is evident from the data that the inheritance of a widow is to have social cohesion between families of the deceased husband and the clan. This agrees with Ambasa-Shisanya's (2007) study that widows might enter inheritance contracts for social, economic, and emotional support. Widow inheritance is a cultural practice observed in many communities in sub-Saharan Africa (Perry et al 2014; Agot et al 2010).

Agot et al (2010) indicate that widow inheritance is usually without effectual consideration of HIV/AIDS challenges. Widow inheritance is practiced because of its cultural recognition. Like the notion of the PEN-3 cultural model, HIV/AIDS prevention must be situated within the cultural and societal contexts (Perry et al 2014). The context of widow inheritance among the Borana pastoralists is not to violate the resource rights of the widow; instead it is to protect the resources of the deceased husband. The inheritance of the wife among Borana pastoralists is supposed to support the children of the deceased husband. The impact of widow inheritance on HIV/AIDS spread has been overlooked. HIV/AIDS communication was not strong enough to break a deep-rooted culture such as widow inheritance. In this context, women-centred culturally driven HIV/AIDS prevention options are necessary to tackle the problem of widow inheritance in the context of a culturally bound community like the Borana pastoralists (Perry et al 2014).

6.4.5.3 Jaala-Jaaltoo sexual networks

Multiple sexual partnerships have been a challenge to prevent HIV/AIDS spread in Africa (Mishra et al 2009). Sexual networks in sub-Saharan Africa contributed to the spread of HIV/AIDS (Helleringer & Kohler 2007). *Jaala-Jaaltoo*, culturally recognised extramarital sexual relations for both men (husbands) and women (wives), confirms culturally recognised sexual networks in Borana (Kaba 2012). As the study by Mtenga et al (2018) reported, extramarital sex is a potential driver of HIV/AIDS transmission for long-term couples in sub-Saharan Africa. The participants, Abdi Tolcha, Jaldesso Waritu, Boku Liban, and Kayo Alake, said that:

> *Jaala-Jaaltoo is common in Borana. Jaala (boyfriend) and Jaaltoo (girlfriend) are known among the community. A wife can have more than one Jaala in secret. A husband can also have more than one Jaaltoo in secret. The number is not fixed. Jaala-Jaaltoo sexual relations are part of strengthening social ties and support among the community* (Abdi Tolcha_Haro Dimtu kebele).

> *Jaala-Jaaltoo is common in our community. I was proud to have more than one Jaaltoo. The women were also proud of having more than one Jaala. I knew these women also had other men, Jaalaa, in the community. We knew each other. However, no one talked about it. I used to support my Jaaltoo without the knowledge of my formal wife. The Jaaltoo also served me delicious food. People are engaged in*

Jaala-Jaaltoo today, including the prominent cultural leaders (Jaldesso Waritu_Haro Dimtu kebele).

In the Borana pastoralist community, there are extramarital sexual relations. There is a culture of Jaala-Jaaltoo. It is also possible to give birth from Jaala-Jaaltoo sexual relations. A child can be labelled as "Finna Booranaa" fi "Finna Gudeedaa." This means "Borana's child" and "Father's child." A woman whose husband died might give birth to someone from the clan. The new baby is also named after the deceased husband (Boku Liban_Renji kebele).

I have four children of my own and two for Borana. I have four children from my formal wife. However, the two were born through the Jaala-Jaaltoo sexual relations. The two children are just for the clan (they are named after the deceased husband) (Kayo Alake_Guto kebele).

It is evident from the data that extramarital sexual relations were practised in the Borana pastoralist community through the culturally recognised *Jaala-Jaaltoo* sexual networks. The data shows that *Jaala-Jaaltoo* sexual relation was beyond sexual pleasure but believed to support bringing up offspring for the clan. Men show their self-pride and social acceptance through having numerous sexual partners. Extramarital sexual activity boosts men's self-esteem and the perception of their own social standing in Africa (Silberschmidt 2001). The data also indicated that extramarital sexual relations through *Jaala-Jaaltoo* were a means of getting additional resources such as land and livestock. The study by Marsiglio (1998) reported that in many African countries, men and women's engagement in extramarital sex is a product of social and cultural conditioning, which often emphasises male domination. Thus, HIV/AIDS communication needs to address the cultural issues of the deep-rooted *Jaala-Jaaltoo* sexual relations. The communication approach should systematically challenge the existing sexual relations (*Jaala-Jaaltoo*) as it has been fuelling the spread of HIV/AIDS among the pastoralist community of Borana. The PEN-3 cultural model is considered for Africa to place culture at the centre of determinants of health behaviour to promote societal health (Cowdery, Parker & Thompson 2010:26).

Cultural identity, relationships, and expectations are important concepts that need to be considered in public health promotion programmes (Iwelunmor, Newsome &Airhihenbuwa 2014). HIV/AIDS communication should effectively respond to the needs and cultural contexts of the population (Raj et al 2011).

The PEN-3 cultural health model, the multiple domain model (Chapter 3, Part II) and the culturally driven conceptual framework (Chapter 4) of this thesis assert that Afro centric HIV/AIDS prevention and communication is crucial for effective social behavioural change to occur. An HIV/AIDS prevention strategy needs to consider the inclusion of the socio-cultural context of the specific social group (Airhihenbuwa 2007a; Zimmerman, Christakis & Meltzoff 2007).

6.4.6 Cultural perspectives of female genital mutilation (FGM)

According to Endalwmaw et al (2020), as well as Gebremichael et al (2018) the practice of female genital mutilation (FGM) still exists in Ethiopia. The national average of the pastoralist areas accounts for 70.8% (Melese 2018). Marital status, customs, beliefs, values, and attitudes have a significant association with FGM practices (Melese 2018). This implies that women (mothers) have positive attitudes towards circumcising girls during earlier age. During the fieldwork, the researcher noticed that FGM was practised in secret among the pastoralist community of Borana. The participants, Kayo Alake and Boku Liban, said that:

> *FGM is done in the rural areas by traditional women. The practice is done in secret during the night. FGM was practised without checking whether the materials such as the blade were contaminated with the HIV virus* (Kayo Alake _Guto kebele).

> *FGM is assumed to discourage early marriage as well as untimely sexual intercourse. FGM is also assumed to encourage obedience to the cultural norm* (Boku Liban_Renji kebele).

> *Some families and communities believe that FGM prepares the girls for marriage with her virginity intact. Culturally, it is recognised as the right procedure to keep girls for marriage. In the rural community, being unable to perform FGM seems taboo. There are situations when girls who did not perform FGM are insulted in the public* (Dugassa Beka_Mata Gafarsa kebele).

The data reveals FGM practices are highly related to cultural norms. A study by Saleem (2013) reported that FGM was performed for different cultural reasons such as discouraging promiscuity, safeguarding, proof of virginity, and a prerequisite for honourable marriage. The study by Melese (2018) indicated that girls who were not circumcised were “promiscuous” and as a result, had less chance of getting married.

The Borana pastoralist community believed that FGM helps to keep girls calm and to abide by the cultural norms to have a blessed marriage. This is consistent with the study by Kinuthia (2010) which reported that FGM was rampant among the Borana community, which led to the spread of HIV/AIDS.

The study by Kinuthia (2010) also established that the Borana community practices FGM to reduce women's sexual interest, to uphold traditions, and a sign of maturity, which is done using crude weapons. These are shared among the victims and this can lead to the spread of HIV/AIDS. FGM practices did not consider the challenges of HIV/AIDS due to the cultural recognition of FGM. However, HIV/AIDS prevention did not give adequate emphasis to FGM that exacerbated the spread of HIV/AIDS. The data indicated that FGM has been carried out for several cultural, religious, and social reasons. Some families and communities believe that FGM will benefit the girl in some way, such as preparing her for marriage or childbirth. This implies that FGM has social, cultural, and religious implications. The PEN-3 cultural health model for Africa (Chapter 3, Part II) and the conceptual framework of HIV/AIDS communication for Borana, should tackle the beliefs and practices concerning FGM through the socio-cultural approach. It is unrealistic trying to tackle the practice of FGM using top-down, one-way, persuasive health communication, unless the message and approaches of communication is culturally tailored (Endalamaw et al 2020). Therefore, there is a need to contextualise the communication by involving the target community, especially women, to address the problem of FGM from the perspective of HIV/AIDS prevention.

6.4.7 Culture of drug use among Borana pastoralists

Traditionally, drug use such as alcohol and chewing khat were considered an urban problem, despite its spread touching every corner including the pastoral communities (Ali 2018). The khat plant (Catha Edulis) is an evergreen shrub that is planted and chewed in eastern and southern parts of Africa and the Arabian Peninsula (Birhanu et al 2016). Chewing khat goes far back in history and has always been a kind of tradition (Alemu et al 2018).

Khat is one of the drugs used in Ethiopia. Borana pastoralists were not known for drinking alcohol and chewing khat. Drinking alcohol and chewing khat were not part of the Borana culture. However, against the established Borana cultural norms and values, drinking alcohol as well as chewing khat has become the norm in the community. Chewing khat and drinking has its own contribution in motivating unsafe sex and exposure to HIV/AIDS.

A significant shift towards casual sex practices is observed in response to the effects induced by the substance and a strong association is observed between khat-chewing, drinking alcohol, and risky sexual behaviours (Godifey Wubneh, Mulaw Desta & Amsalu Kahsay 2021; Abate et al 2018; Seme, Mariam & Worku 2005). HIV/AIDS communication among the Borana pastoralist community should consider the culture of drug use. The in-depth interview participants, Boku Liban and Kayo Alake, said that:

> *Drinking alcohol was intolerable among the Borana. Gadaa leaders were not allowed to drink alcohol. Today, there are many types of alcoholic drinks in nearby villages. Most of the cultural leaders in Borana drink alcohol* (Boku Liban_Renji kebele).

> *Ancestors never consumed alcoholic drinks. Drinking alcohol was against the profound culture of Borana. Yet, alcoholic drinks have become common today due to cultural diffusion through movements of people from rural to urban areas. Drinking alcohol exposes the community to unnecessary sexual intercourse. Alcoholic drinks enforce early marriage and unwanted pregnancy* (Kayo Alake _Guto kebele).

In addition, the researcher observed that khat is transported from the neighbouring regions and zones to Arero along the Yabello road. The in-depth interview participants, Boku Liban, Doyo Waritu and Kayo Alake, explained that:

> *Chewing khat was not acceptable and familiar in Borana. However, khat has become common in the pastoralist community. Chewing khat has been ruining the good cultural norms, values, and health behaviour of the community. The use of drugs initiates extramarital sexual relations that expose them to HIV/AIDS. They may decide to have unsafe sex* (BokuLiban_Renjikebele).

> *Alcohol was introduced to our culture by the highlanders (urban dwellers). Chewing khat was also not in Borana culture. It is believed that HIV/AIDS was introduced to the pastoralist community by the highlanders. School environments are surrounded by drug use that exposes the youth to drug addiction. Drug use continued influencing our good culture* (Doyo Waritu_Guto kebele).

> *The Borana zone is nearer to the border. The way to Kenya is along the Borana road. This creates cultural exchanges between the Borana community and other cultural groups from the centre (Finfine) as well as Kenya.*

The Borana people are facing new practices, such as drinking alcohol and chewing khat, which were unfamiliar to the Borana. These practices expose people to HIV/AIDS (Kayo Alake_Guto kebele).

It is evident from the data that substance abuse is one of the most threatening public health issues of contemporary society (Ali 2018). The cultural shift in using drugs such as alcohol and khat has been threatening the Indigenous Borana cultural values and norms. HIV/AIDS communication failed to work on the emerging culture of drug use among the community that exposes the danger of HIV/AIDS. People with heavy episodic drinking patterns are more prone to use condoms inconsistently and incorrectly, experience sexual violence, and acquire an STI, including HIV/AIDS (Ramjee & Daniels 2013). Substance use such as khat and alcohol has become a major public health concern (Kassew et al 2023; Cook et al 2018). Substance use in Ethiopia has association with sexually transmitted diseases like HIV/AIDS (Kassew et al 2023; Mitiku, Mossie & Fekadu 2012). The emerging culture of drug use among the pastoral community hamper HIV/AIDS communication. The multiple domain model asserts that HIV/AIDS communication should consider factors out of the individual's control, such as the environmental factors that expose the community to health risks (Zimmerman, Christakis & Meltzoff 2007). The use of drugs such as alcohol and khat among the Borana pastoralists should be tackled not only from a medical perspective but also from the socio-cultural perspectives.

6.4.8 Livestock marketing and HIV/AIDS risks among Borana pastoralists

In East African countries, such as Ethiopia, rural areas are threatened by the problem of HIV/AIDS because of the high mobility of the people. This mobility serves different purposes, such as moving great distances to urban areas to sell livestock (Lagarde et al 2000). Mobility and migration enable the virus to shift from urban centres to the countryside (Colvin & Sharp 2000). HIV/AIDS communication should consider the mobility context of the community. Hein-depth interview participants, Boku Liban and Jaldesso Wayu, pointed out that:

Borana male pastoralists move long distances to sell livestock. They stay in hotels for days. This exposes the pastoralists to extramarital sexual intercourse. Most of the pastoralists do not use condoms. The traditional market culture of pastoralists exposes people to HIV/AIDS. HIV/AIDS communication failed to place emphasis on the nature of a traditional livestock market in terms of the HIV/AIDS spread (Boku Liban_Renji kebele).

> *Cattle herding is well known among the Borana. Pastoralists are drawn to livestock production. Livestock marketing is a major source of income. To sell livestock, pastoralists move to far away towns on foot. In most cases, they are away from home for a week. During this time, they stay at hotel. There is no adequate research regarding the effect of livestock marketing on the HIV/AIDS spread* (Jaldesso Wayu_Haro Dimtu).

It is evident from the data that traditional livestock markets have their own contribution to the spread of HIV/AIDS in the Borana pastoralist community. The male pastoralists are expected to walk long distances to sell their livestock. This mobility exposes them to the risks of HIV/AIDS. The study by Camlin and Charlebois (2019) reported that there is a significant relationship between mobility and sexual behaviour. Mobility due to socio-economic purposes exacerbates the risk to HIV (Shira et al 2012). Thus, there is a need to contextualise HIV/AIDS communication in terms of the mobile nature of the pastoralists for different purposes, such as livestock trade. The HIV/AIDS prevention and communication approach should be considered in the context of smaller towns and market centres in sub-Saharan Africa (Berhane et al 2008).The PEN-3 cultural model (Chapter 3,Part II) and the culturally driven conceptual framework of HIV/AIDS communication (Chapter 4) asserted that HIV/AIDS communication in Africa needs to consider cultural, social, situational, and environmental contexts in the local community for effective social behavioural change (Airhihenbuwa 2007a; Zimmerman, Christakis & Metlzoff 2007). Developmental-oriented activities in the pastoral society should consider specific issues and contexts in the cultural community (Rogers et al 2021). Additionally, in line with the conceptual framework developed in Chapter 4, HIV/AIDS communication in Borana should consider the socio-cultural path of disease prevention strategies that consider the specific characteristics of the Borana pastoralists.

6.5 GENDER DIMENSION OF HIV/AIDS COMMUNICATION

This study is based on the cultural framework of HIV/AIDS communication. The theme is focused on tailoring HIV/AIDS communication to the gender context of the Borana pastoralist communities. This section of the thesis specifically presents gender-related data that HIV/AIDS communication among the Borana pastoralists should consider for its gender appropriateness.

The HIV/AIDS epidemic has been fuelled by gender inequality and disparity resulting in the violation of women's reproductive rights (Girum et al 2018; Mtengaetal 2018; Ramjee & Daniels, 2013).

6.5.1 Gender inequalities among Borana pastoralists: a female perspective

In sub-Saharan Africa various factors, such as social, cultural, economic, and structural factors, expose women (especially the underprivileged pastoralist women), to the problem of HIV/AIDS (Chala & Haro 2023; Anbacha & Kjosavik 20219; Anbacha & Kjosavik 2019b; Ramjee & Daniels 2013). FHAPCO (2007) reported that women and girls in Ethiopia are at a greater risk of HIV infections due to their low position in the society. The pastoralist community in Borana is encircled by gender roles that have implications on the effort to communicate HIV/AIDS. In Africa, cultural expectations of masculinity encourage men to assume the patriarchal attitude that wives, partners, and daughters are the possession of men (Ramjee & Daniels 2013). A woman is her husband's property as "bride payments" where made. The bride's family receives financial compensation from the potential husband (Ramjee & Daniels 2013).

In Borana, men have the rights to resources. Structural vulnerabilities place women at risk of gender inequality and gender-based violence (GBV) (Ramjee & Daniels 2013). The PEN-3 cultural model aims to address the complexity of health issues by addressing cultural beliefs and practices that are critical to health behaviours and should either be encouraged, acknowledged, and/or discouraged (Iwelunmor, Newsome & Airhihenbuwa 2014). The PEN-3 cultural model contextualises the role of culture in shaping the understanding of, and actions towards, health and illness (Iwelunmor, Newsome & Airhihenbuwa 2014). Health communication in Africa should consider social relations, gender roles and expectations, and the deep-rooted cultural identities of the target community to bring social behavioural change (Iwelunmor, Newsome & Airhihenbuwa 2014). The participants, Tura Kurkura and Boku Liban, said that:

> *Women in the pastoralist community are expected to carry out domestic activities. Men and the youth are expected to move long distances with their cattle. Men are also responsible to protect their lands and livestock. Selling livestock is assumed to be the role of men. Men are suspected to be spreading HIV/AIDS* (Tura Kurkura_Renji kebele).

> *Men (husbands) decide on resources. The decision of men on financial matters may give them the opportunity to have multiple sexual partners. Control over resources allows men the opportunity to marry many women* (Boku Liban_Renji kebele).

The data confirms that women pastoralists are less empowered. Pastoralist families encounter challenges because of the pastoral ecology and the climatic conditions. The dominance of men in the pastoralist community has created more opportunities for men to look for many extramarital sexual partners as well as polygamy without the consent of the spouse. This shows that pastoralist women bear a disproportionate burden caused by drought factors as well as the traditional roles and structural inequality in accessing basic resources (Anbacha & Kjosavik 2019b). Coppock et al (2013:22) have argued that women pastoralists "are especially marginalised because they are illiterate, unskilled, disempowered, and engaged in daily labour". Women pastoralists can be susceptible to HIV/AIDS problems due to gender discrimination and inequality. The gendered dimension of HIV/AIDS communication should help to ensure appropriate HIV/AIDS prevention strategies that would address the interest of pastoralist women in Borana. Ramjee and Daniels (2013) also reported that in Africa, economic inequalities keep money, land, and other resources out of women's reach, causing them to be financially dependent on men, unable to negotiate safe sex or condom use with a partner, and more at risk of violence. Gender inequalities and power relations reduce economic and social opportunities for better lives among women and increases risky sexual behaviour (Mbonye et al 2012). Extramarital affairs have a gender dimension in which women can be more exposed to extramarital affairs and HIV infection based on various gender dynamics, including women's economic hardship, social beliefs, and masculine norms (Mtenga et al 2018). Women's economic dependency adversely contributes to risky behaviour and HIV (Augustine Bala et al 2022). The gender-based economic discrimination in the pastoral population paves a way for the rapid spread of HIV/AIDS (Chala & Haro 2023; Anbacha Kjosavik 2019). Therefore, HIV/AIDS communications should consider the gender issue as a major contextual domain to tackle HIV/AIDS problems in pastoralist communities like Borana (Mtenga et al 2018; Ramjee & Daniels 2013). As discussed in the conceptual framework (Chapter 4), there should be socio-cultural oriented HIV/AIDS communication among the Borana pastoralist community to address the gender discrimination that exposes women to the risks of HIV/AIDS. The researcher noted that women (wives) are expected to obey their husbands in the Borana pastoralist community. Wives are not expected to confront their husband's views.

The discussion between men and their respective spouses is hierarchical. This is consistent with the study by Ramjee and Daniels (2013), Chala and Haro (2023), as well as Anbacha and Kjosavik (2019) who reported that the dominant patriarchal culture and society in Africa exacerbates women's inferiority and their disparate health status. The participants, Abdi Tolcha, Kayo Alake, and Boku Liban, said that:

> *Women (wives) are not expected to complain about men's (husbands) rights. The culture favours men more than women. Men have the right to decide about his sexual partners and sex interests. Most Borana pastoralists rarely attend schooling. Schools were inaccessible for the pastoralist families. Most families expect their daughters to marry. Early marriage is observed among the community. Early marriage may expose under-aged girls to health problems* (Abdi Tolcha_Haro Dimtu kebele).

> *Men have more opportunity for education. Girl's education is discouraged among Borana pastoralists* (Kayo Alake_Guto kebele).

> *Girl's education is not common among the pastoralist community. Girls are mostly brought up for marriage. A girl who marries someone without losing her virginity has great recognition and acceptance among the clan. A woman who keeps her virginity until marriage receives valuable gifts from the husband's family. Girls who lose their virginity at an earlier age are forbidden to marry someone in the community* (Boku Liban_Renji kebele).

It is evident from the data that women pastoralists encounter varied challenges because of gender inequality. Borana girls, unlike boys, have less opportunity for schooling. Girls are encouraged to marry without their interests are taking into consideration. Families have little interest in girls' education. It is not given adequate attention in Borana. Pastoralist regions in Ethiopia benefitted the least from the efforts made so far concerning education (MoE 2013). Girls' education in the Borana pastoralist area is overlooked (Kenea 2023). Members of the pastoralist community see schooling in terms of the livestock possession and herding. Schooling children means losing livestock and losing livestock means losing the very self of the community (Kenea 2023). People with little or no education have limited access to safe sex information (Ramjee & Daniels 2013).

The Oromo people show immense value for children. In Oromo, *Ijoollee* (children) is derived from *ijaa* (eye). Oromo cares for his children as his eye.

This is how the Oromo of Ethiopia contributed *Guddifachaa* (adoption) via the Gadaa culture. The Oromo people also have the culture of *moggaasaa* (naming) in which they accept and bring up someone as their own son or daughter. The Oromo further has the culture of *harma-hodhaa* (breastfeed) through which someone from other ethnic groups might be recognised as Oromo and get appropriate care and treatment among the Oromo family and clan. The Borana Oromo, main Oromo clan, also gives great attention to *Finna* (generation). Borana women (wives) are expected to give birth. The participants, Kayo Alake and Abdi Tolcha, said that:

> *Women who do not give birth are not respected in the community. "Niitiinyoohingaraachofnerakkoojabdu" This is like saying: "If a wife cannot conceive, that will be problematic.' The social expectation leads husbands to marry another woman or look for extramarital sexual intercourse to get more children. Women who cannot conceive due to fertility problems may be divorced. Such family separation would expose women to multiple and unsafe sexual practices* (Kayo Alake_Guto kebele).

> *A brother of the eldest wife is responsible for the home if the father dies. All the other brothers and sisters, irrespective of their biological mothers, are guided by the older brother. The eldest wife occupies a senior position. In family discussions, boys are dominant. Girls are silent in the public sphere. This is part of the culture. However, the health workers rarely consider such issues in HV/AIDS communication* (Abdi Tolcha_Haro Dimtu kebele).

The feedback indicated that when women are unable to give birth in Borana it gives men the opportunity for polygamy. The need for more children would expose the community to unsafe sexual practices. Family ties have crucial roles in the community. Older boys have more decision power than the youngsters do. Compared to older boys, older girls have less power in the community because they are girls. Elder wives have more decision and resource power compared to younger wives. The less powerful groups such as girls and younger wives have less position in the community, which might affect their opportunity to participate in community affairs. The position of a wife in the community is different, based on the rank assigned culturally (first wife, second wife, third wife) (Serbessa et al 2016; Dugassa 2014). HIV/AIDS communication overlooked the family, as well as the social ties and expectations that might affect HIV/AIDS communication.

Oromo never compromises on his land. Culturally, it is called "*Laftilafee Dugdaati*". This means: "Land is the backbone." In the Oromo community, it is called "*Lafa abbaa Koo*". It means, "My father's land". In Oromo, sons inherit the land. Traditionally, giving birth to a baby boy creates astonishing pleasure among the families as well as the clan. As a result, the attention given to children is different because of the gender orientations of the community. The participants, Abdi Tolcha and Kayo Alake, said that:

> *Boys have more cultural responsibility and expectations. Unlike boys, girls may not stay within the community after marriage. Girls marry someone from another moiety, leaving the land of her family. Girls do not have the right to inherit the land of her family* (Abdi Tolcha_Haro Dimtu kebele).

> *Boys are preferred to preserve and protect the land and resources of the family "Dhalaan kan algaati", meaning, "Females belongs to others"* (Kayo Alake_Guto kebele).

In the pastoralist community, there is a social expectation that men who have only daughters seek another marriage and/or extramarital sexual relations which may expose them to health problems such as HIV/AIDS. One of the participants, Boku Liban, explained the issue by saying:

> *Men in the community may marry more than one girl/woman to get baby boys. Giving birth to only baby girls degrades the value of the wife. The husband celebrates in public when the wife gives birth to a baby boy. The husband usually puts a piece of cultural cloth named "marataa" on his head when his wife gives birth to a baby boy. Having such marataa on the head is a symbol of pride* (Boku Liban_Renji kebele).

The feedback confirmed that social expectation has its own contribution to the spread of HIV/AIDS. The data showed that the expectation for boy children is more within the pastoralist families, and it paves the way to marry numerous times to get baby boys. Polygamy and/or extramarital sexual intercourses are practised to give birth to a greater number of boys. However, the findings indicated that these sexual practices were not in consultation with medical professionals concerning testing for HIV/AIDS. In the context of the Borana pastoralists, as the data indicated, the desire for children is usually very high, and most often women who had more girls never give up producing children for the fact that they may have a chance to get a baby boy. Sometimes woman who had no baby cannot tolerate to stay with her husband. This would lead to polygamy and/or extramarital sexual relations to have more children, especially baby boys.

Polygamous sexual relations expose people to the risk of HIV/AIDS in the culturally bound community (Damtie et al 2021). There is a need to understand and address the multiple drivers of extramarital affairs by considering the context-sensitive interventions (Damtie et al 2021; Mtenga et al 2018).

6.5.2 Female rural-urban movements and the spread of HIV/AIDS

Women migrate to the urban areas to get jobs, an income, education, healthcare, and other services (UNFPA 2007). Pastoralist families have been sending girls to relatives in the towns for better education and jobs. The participants, Boku Liban and Tura Kurkura, said that:

> *Most girls in the pastoralist community are leaving their families for better jobs in towns. They face sexual harassment and other forms of gender abuse. Most of these girls/women are harassed by their employers and/or other members of the family* (Boku Liban_Renji kebele).

> *I have a daughter. She decided to move to town where her uncle lives. After a while, her behaviour changed. Her approach changed. Her respect for elders changed. In the end, she married someone without the consent of the family and her uncle.*
> *The husband left her in the rented house and flew back to his native place of residence. She was not happy with her life. She left her baby and went out* (Tura Kurkura_Renji kebele).

> *Urbanisation has been affecting the Borana Indigenous cultural values and norms. The youth are migrating to urban areas without getting appropriate counselling on how to adapt to the urban culture. They have been looking for better jobs. Girls are also leaving their families and moving to town for better education and jobs. Sometime girls are exposed to unprotected sexual practices and unwanted pregnancy. They are also forced into early marriage* (Guyo Liban_Mata Gafarsa kebele).

The feedback indicated that internal migration due to economic problems exposed the girls/women to sexual abuse and unwanted pregnancy. Rural-urban migration causes a cultural behavioural change; migrants are expected to immerse themselves into new urban cultures and norms, different from their place of origin (Saggurti et al 2011).

The cultural shifts due to migration exposed especially pastoralist women to the problem of HIV/AIDS. However, health institutions in the pastoralist community overlooked integrating the problems of migration into HIV/AIDS communication. Urbanisation replaces the traditional village norms with a modern urban culture with fewer restrictions on sexual behaviour and marriage (Ramjee & Daniels 2013). Many individuals migrate due to better job prospects or are forced to migrate due to political instability, war, and famine (Ramjee & Daniels 2013). Mobility due to socio-economic impacts, gender inequalities, and stigma/discrimination exacerbate HIV risks (Dzomba et al 2022; Shira et al 2012). Gender continues to be important: while men are more mobile than women, women's mobility particularly heightens their HIV acquisition risks (Camlin & Charlebois 2019). In this context, pastoralists' mobility due to factors such as socio-economic conditions and the climate that expose them to the risks of HIV/AIDS should be considered. HIV/AIDS programme planners need to integrate HIV/AIDS communication with the pastoralists' realities so that the driving factors that expose people to the HIV/AIDS epidemic can be addressed through stakeholder's collaboration. Additionally, in line with the conceptual framework developed in Chapter 4, HIV/AIDS communication in Borana should consider the socio-cultural path of disease prevention strategies that consider the specific features of the Borana pastoralists. The PEN-3 cultural model, the multiple domain model, and culturally driven conceptual framework of HIV/AIDS communication have significant value to address culturally tailored HIV/AIDS messages among the Borana pastoralist community (Camlin & Charlebois 2019; Zimmerman, Christakis & Meltzoff 2007).

6.5.3 Gender inclusive HIV/AIDS awareness campaigns among Borana pastoralists

Efforts to improve engagement in HIV care and treatment should address the inequitable and restrictive gender norms (Fleming et al 2016). Gender norms may encourage men's dominance over household decision-making and control over women in Africa (Jewkes & Morrel 2010). The data reveals that a gap has been observed pertaining to gender inclusion to communicate HIV/AIDS messages. The language used in HIV/AIDS communication appeals more to men. Accordingly, the in-depth interview participants, Boku Liban and Kayo Alake, told us:

> *Health workers use language that is more masculine while educating, informing, and communicating the risks of HIV/AIDS. The message seems more appealing to the male groups* (Boku Liban_Renji kebele).

HIV/AIDS language is more masculine. Men are responsible for HIV/AIDS. The communication and message design do not consider women (Kayo Alake_Gutokebele).

Most women consider HIV/AIDS as a male disease. In teaching about HIV/AIDS, I observe while health workers communicate in the native language of the community: "Dhibeen kuni lma namaa fixaa jira" meaning, "This disease is destroying mankind" (Guyo Liban_Mata Gafarsa kebele).

The data indicated that there has been deep-rooted misperception among the community. Most women (wives) in the pastoralist community attribute HIV/AIDS to men (husbands) (Thomson et al 2015). The data further confirms that there is a gender bias in communicating HIV/AIDS. Language was not taken into consideration when communicating the risks of HIV/AIDS. The language of HIV/AIDS communication in the pastoralist community seemed more appealing to the masculine gender. Health decisions of a target community could be influenced by contextual domains such as language, culture, gender, age group, and experience with the health topic in question (Vermund, Van Lith & Holtgrave 2014:25). The language consideration serves to eliminate the alienation of the messages, makes the message culturally appropriate, as well as geographically and educationally more understandable and acceptable (Ahmad 2012:17). It is crucial to link HIV/AIDS messages to the gender context for effective health decisions. For a culturally bound community like the Borana pastoralists, hierarchical gender roles such as the notion of male sexual entitlement, the low social value and power of women, and ideas of manhood linked to the control of women, result in lower levels of education among women, fewer public roles for women, the lack of family, social and legal support, and the lack of economic power for women (Ramjee & Daniels 2013). Gender inequalities and power relations reduce economic and social opportunities for better lives among women and increase risky sexual behaviour (Mbonye et al 2012). As the data indicated, there are gaps among health organisations in developing enhanced, targeted, and inclusive HIV/AIDS messaging approaches that address misinformation, myths, and the lack of understanding HIV prevention and care among the pastoralist community (Mapingure, Mukandavire& Chingombe 2021).

6.6 A USER-FRIENDLY HIV/AIDS COMMUNICATION APPROACH

This theme focuses on the pastoralist-specific communication approaches. This section presents communication-related data that HIV/AIDS communication among the Borana pastoralists should consider for its appropriateness.

6.6.1 Familiar language: implication on HIV/AIDS communication

The HIV/AIDS communication material should consider the language of the target community. This enhances audiences' message reception and understanding. Language plays a guiding role in the maintenance or alteration of the community's social fabric (Dugassa 2006:4). An individual's ability to access, process, and comprehend health-related information with the goal of making appropriate decisions is crucial. Various socio-demographic characteristics such a gender, age, and economic status may influence health literacy (Mgbako, Conard & Mellins 2022; Rebeiro et al 2018; Waldrop-Valverde et al 2010). Low health literacy has been linked to inadequate engagement in care and may serve as a contributor to poor health outcomes (Mgbako, Conard & Mellins 2022; Rebeiro et al 2018). HIV/AIDS communication and language use should fit the audience's reality. However, the data indicated that HIV/AIDS communication and promotional materials were originally prepared in English and/or Amharic languages, which are not the native language of the Borana pastoralists. Audiences should understand health material and obtain and apply information related to health matters (Thomson et al 2015). The participants, Tura Kurkura, Abdi Tolcha, and Boku Liban, stated that:

> *Health workers use the language of Borana. Some health workers also use a technical/professional language, which is not familiar to the local people* (Tura Kurkura_Renji kebele).

> *Health workers sometimes use non-standardised languages which includes unfamiliar vocabulary* (Abdi Tolcha_Haro Dimtu kebele).

> *There are posters, brochures, and flyers to inform people about HIV/AIDS. There are also notices and precautions in written language. Some HIV/AIDS teaching materials are not prepared in the native language of Borana* (BokuLiban_Renji kebele).

The data shows that technical language obscured HIV/AIDS communication among the pastoralist community.

In addition, the data revealed that HIV/AIDS communication among the pastoral community did not adequately use the linguistic and cultural resources of the local community. The health promotional materials and programmes overlooked the cultural sensitivity and culturally relevant symbols. Health workers need to consider the language, cultural symbols, and literacy of the target pastoralist community (Singleton &Krause 2009). In addition, the data indicated that HIV/AIDS communication materials within the pastoralist community were translated from other languages such as Amharic and English. The participant, Kayo Alake, commented on the issue:

> *HIV/AIDS communication materials are not in the original language and context of Borana. The materials are translated from other languages such as Amharic or English* (Kayo Alake_Guto kebele).

The data shows that HIV/AIDS communication materials were translated from other languages to Afan Oromo. The materials were not prepared in the native language and were not in accordance with the cultural values or norms of the pastoralist community. These materials lacked context and original sensibility for the pastoralists. The stories used to teach HIV/AIDS should be in line with the Borana pastoralist's lived experiences. HIV/AIDS intervention materials should match the observable social and behavioural characteristics of the target community (Kreuter et al 2003).The use of non-verbal communication, together with verbal communication, can assist to grab the attention of the target community (Lettiah & Nendanga 2020). However, the participants, Boku Liban and Jaldesso Wayu, said:

> *Mallatoolee aadaa Booranaa hubachuun waliigaltee uumuuf akka dansaa nama gargaara. Booranni nama aadaasaa kabaju nikabaji. Atuu yoo na fakkaatte irra caalaa sittin kala'aa. Aadaa keenyatti yoo keessummaa taate walitti dhufeenya uumuufi wal-hubachuun yeroo haga tahe fudhachuu mala. Kan namoota HIV/AIDS barsiisaniis akkasuma. Garuu, namoonni tokko tokko ni rakkatu. Kun ammoo wal-hubannaa miidha* (Boku Liban_Renji kebele).

The translation for the above is:

> *Understanding Borana metaphorical speeches is good. The Borana respects someone who respects his culture. Understanding Borana cultural symbols would help to understand each other clearly. I approach you more if you resemble me. If you are unfamiliar to our (Borana) culture, creating good relationships and*

understanding may take time. The issue of HIV/AIDS communicators is also like this. However, some people face difficulty (Boku Liban_Renji kebele).

Health workers who are unfamiliar to the pastoralist community face difficulty in communication. Healthcare workers dress style is sometimes against our cultural dressing (Jaldesso Wayu_Haro Dimtu kebele).

It is evident from the data that health workers in the Borana pastoralist community did not consider the importance of nonverbal symbols such as dress style, cultural signals, ways of speaking (tone), and artefacts to address HIV/AIDS messages effectively. Nonverbal cues, including cultural symbols, can be utilised to maximise health communication (Lettiah & Nendanga 2020). The participants, Jaldesso Wayu and Boku Liban, reflected on this issue by saying:

We (Borana) recognise and value communication that considers our cultural orientations. Healthcare workers may not recognise these cultural symbols and practices. Why do health posts use the photos of people wearing urban styles to teach the pastoralists about HIV/AIDS? Why do health posts focus on photos of women to promote condom use? (Jaldesso Wayu_Haro Dimtu kebele).

Most photographs/posters used to teach about HIV/AIDS are prepared in the context of urban culture. They are not prepared in the cultural contexts of Borana pastoralists (Boku Liban_Renji kebele).

The feedback confirms that there were gaps in contextualising HIV/AIDS communication material to the situations of the Borana pastoralist community. HIV/AIDS communication style and materials did not consider the unique features of the pastoralist community. Illustrated materials and case histories have a greater impact to convey health messages (Ahmad 2012).

Materials used in health, including HIV/AIDS, campaigns should be suitable to the context on the ground. Many lower- and middle-income countries of Africa, such as Ethiopia, have high levels of linguistic diversity, meaning that health information and care is not available in the languages spoken by much of the population.

The consideration of language needs in formal planning and reporting in the context of HIV/AIDS-related healthcare is extremely low (Bachelor et al 2019).

Language shapes how people understand and communicate health experiences (Balogun 2019; Crocker & Smith 2019). Language terminologies and/or expressions related to gender should be appropriate. In addition to terminologies, body language and images should convey an appropriate message to the target community (Balogun 2019; Crocker & Smith 2019). Low health literacy has been linked to inadequate engagement in care and may serve as a contributor to poor health outcome (Mgbako, Conard & Mellins 2022; Rebeiro et al 2018). As the PEN-3 cultural model states, HIV responses in the context of Africa need to be tailored to the specific cultural contexts such as the language of the local community (Khandu, Togbay& McFarland 2021; Iwelunmor, Newsome &Airhihenbuwa 2014; Airhihenbuwa 2007a). This implies that HIV/AIDS communication and language use among the Borana pastoralist community should fit the audience's familiar symbols, signs, and language for effective communication. In line with the socio-cultural approach conceptual framework developed in Chapter 4, HIV/AIDS communication in Borana should considers the socio-cultural path of disease prevention strategies. In addition, HIV/AIDS communication in Borana should consider an Afro centric health communication model like the PEN-3 cultural model that emphasises the socio-cultural context in the target community for effective disease prevention and social behavioural change.

6.6.2 Understanding pastoral-friendly HIV/AIDS communication

Public health efforts to reduce the spread of HIV have undergone a major shift from separate models for prevention and treatment to the current focus on combination prevention strategies, which simultaneously addresses biomedical, behavioural, and social/structural levels (Tomori et al 2014). HIV/AIDS communication is not "a one-time, one-way" communication act (Storey et al 2014). In Africa however, health communication is considered an add-on task in the health sector industry (Storey et al 2014). HIV/AIDS communication should be integrated with the cultural expectations of the target population to convey a clear message (Ford et al 2005). The participants, Jaldessa Wayu and Boku Liban, explained:

> *HIV/AIDS communication follows the formal communication path. The informal networks in the community are not considered. Cultural symbols such as the Odaa tree is not well utilised. The communication is dominated by the professionals and political elites. Dialogue among the Borana is attractive under the sacred tree named Odaa (sycamore tree). HIV/AIDS communication in the community focuses more on individuals* (Jaldessa Wayu_Haro Dimtu kebele).

Health posts, clinics, schools, and offices are used to address HIV/AIDS messages. Nowadays, however, HIV/AIDS issues seem to have been overlooked because of the Covid-19 pandemic (Boku Liban_Renji kebele).

The data shows that the pastoralist's informal communication approaches and socio-cultural networks were not well utilised to address HIV/AIDS messages. The communications setting did not consider the spiritual, psychological, and emotional make-up of the pastoral community. Healthcare workers failed to value the cultural symbols such as the *Odaa* tree that has inherent value to the host community. This contrast with the study by Ahmad (2012) which reported that message reception could be influenced by socio-cultural, psychological, and demographic profiling of the audiences. Pastoralist communities usually move with their livestock. Dry season is a serious challenge for the pastoralists. The health system did not consider the pastoral environment and climatic variations when addressing the health interests of the pastoral community during long drought seasons. The participant, Doyo Waritu, explained that:

In drought seasons, the pastoralists move long distances with their livestock. During these seasons, pastoralists never think about HIV/AIDS. Health workers stay in urban areas and health centres during the long drought seasons (Doyo Waritu_Guto kebele).

The feedback revealed that HIV/AIDS communication among the pastoralist community was influenced by seasons. Yet, there was no planned communication to address HIV/AIDS messages during hardships such as long droughts. HIV/AIDS communication and prevention strategies were not planned in terms of climate issues. The study by Burke, Gong, and Jones (2014) reported that in sub-Saharan Africa, long drought periods due to climate change, and exposes people to HIV/AIDS because of migration. HIV/AIDS communication among the Borana pastoralists was not planned in terms of long drought seasons. HIV/AIDS can be framed as an environmental justice issue due to the intimate connection that exists between natural resources and the transmission and progression of HIV/AIDS (Lieber et al 2021). The participant, Abdi Tolcha, said that:

HIV/AIDS communication in the pastoralist community mostly uses oral channels. Health workers use oral languages to communicate about HIV/AIDS. The oral communication is mostly used during formal gatherings (Abdi Tolcha_Haro Dimtu kebele).

The data showed that healthcare workers in the Borana pastoralist community focused more on the formal channels of communication (government structure) to address HIV/AIDS messages. The informal channels of communication such as social networks, coffee ceremonies, cultural gatherings, and ritual ceremonies that are more powerful than the official government structure were not utilised. HIV/AIDS prevention should focus on prevention that considers the collective behaviour rather than individual beliefs and perceptions (Cain et al 2013; Guha et al 2012; Kippax et al 2013). Boku Liban, Doyo Waritu, and Abdi Tolcha, pointed out:

> *HIV/AIDS communication tends to focus more on the individual. The communication did not consider the cultural influence and peer pressure* (Boku Liban_Renji kebele).

> *Pastoralists are more familiar with the cultural paths of communication. Health workers are more familiar with the kind of communication that is channelled from the source to the target audiences; top-down* (Doyo Waritu_Guto kebele).

> *The flow of communication among Borana pastoralists is culturally from the family to their children and rarely vice versa* (Abdi Tolcha_Guto kebele).

The above data shows that the HIV/AIDS communication approach in the pastoralist community underemphasised the community ties, which are more essential than the family ties in Borana. Communicating to individuals alone cannot be effective in the HIV/AIDS campaigns for the collectivist culture; individual decision is influenced by the families and communities' socio-cultural ties. Indeed, the social behavioural change was less considered among the pastoralist community. Collectivism values interdependence and connectedness (Heu, van Zomeren& Hansen 2019). HIV/AIDS communication with specific reference to social behavioural change among Borana pastoralists needs to consider the informal channels of communication, collectivist behaviour, and the socio-cultural ties that would help to address HIV/AIDS messages. Participatory health communication focuses on audiences' perspectives that foster dialogue, which allows for the sharing of information, perceptions, and opinions among the various stakeholders and thereby facilitate their empowerment (Tufte & Mefalopulos 2009). Top-down health communication overlooks understanding the specific communication needs and context of the audience (Parker & Becker-Benton 2016). The participants, Boku Liban and Kayo Alake, pointed out:

HIV/AIDS massages are designed centrally. The communication is top-down. The pastoralists are not engaged in the message design. They do not have a chance to comment on the cultural relevance of the message. The messages do not adequately consider the pastoralist context (Boku Liban_Renji kebele).

We (cultural leaders) know how to communicate with our community. We have no chance to add our point on how to make HIV/AIDS materials suitable to the context of the pastoralist community (Kayo Alake_Guto kebele).

The feedback indicated that HIV/AIDS communication among the Borana pastoralist community overlooked community engagement while preparing the communication materials. The communication and message design had a top-down approach. The people had almost no say in designing and planning HIV/AIDS messages within the context of the local realities. HIV/AIDS interventions in the pastoralist regions of East Africa, like Borana, were not well contextualised and integrated into to the needs of those impoverished populations as well as national HIV/AIDS programmes (Serbessa et al 2016). There is an over-reliance on the urban professionals and politicians to be the intermediaries between rural communities and development actors regarding development concerns in the pastoral community (Rogers et al 2021). Development related communication, including health communication, in the pastoral society of sub-Saharan Africa relied on a simplistic approach that overlooked the complexity of overlapping and often contested issues in the cultural community (Rogers et al 2021). The PEN-3 cultural health model indicates that HIV/AIDS communication in the cultural community of Africa needs to consider the context on the ground, like the degree of literacy (Iwelunmor, Newsome &Airhihenbuwa 2014; Cowdery, Parker & Thompson 2010; Airhihenbuwa 2007a). In addition, the multiple domain model states that health communication, including HIV/AIDS communication, should consider the contextual factors in the community (Zimmerman, Christakis & Meltzoff 2007).The culture-centred approach to health communication calls for attention to dialogue and locates cultural participants in the culture being studied (Ambar et al 2009).

6.6.3 Condom promotion activities among Borana pastoralists

Using a condom is one of the HIV/AIDS prevention strategies to alleviate the spread of HIV/AIDS in Ethiopia (Hamidi, Regmi & van Teijlingen 2023; Mohammed et al 2016). Even though public health organisations have encouraged people to use condoms, many people

in sub-Saharan Africa do not, especially in sexual encounters with someone that they are living with or are married to (Broderick et al 2023).

Condom promotion and use is more common in the urban areas than the rural community in Ethiopia (Mohammed et al 2016). The participants, Boku Liban, Jaldesso Wayu, Dugassa Beka and Boku Liban, stated that:

> *The pastoralists are not free to talk about condoms. The cultural institutions are not adequately utilised to break such cultural silence* (Boku Liban_Renji kebele).

> *Condoms are used in hotels in the urban areas. Rural people are more culturally bounded. It is uncommon to use condoms in the pastoralist community* (Jaldesso Wayu_Haro Dimtu kebele).

> *Condoms affect fertility. Condoms reduce sexual pleasure. In the urban areas, people are afraid to buy condoms in the daylight. Talking about sex is a cultural taboo in Borana* (Dugassa Beka_Mata Gafarsa kebele).

> *The price of condoms is also increasing from time to time. Selling condoms has become a business. Condoms incur additional costs* (Boku Liban_Renji kebele).

The data showed that condom promotion and use was uncommon among the pastoralist community of Borana. The healthcare workers failed to tackle the taboo topic of condoms among the pastoralist community. The data further indicated that there is a misperception among the pastoralists about the use of condoms. In addition, condom promotion among the pastoral community of Borana was hampered by the cultural factors. Low utilisations of consistent condom use in Ethiopia are associated with distinct factors such as cultural perceptions (Wolde et al 2020). The data indicated that the cost of condoms and the taboo topic of sex hampered HIV/AIDS communication in the Borana pastoralist community. There has been a misperception that condom use diminishes sexual pleasure, trust, and relationships (Ayele et al 2020). Ramjee and Daniels (2013) reported that in sub-Saharan African countries, the use of condoms or negotiation to use condoms is not always on the woman. The social marketing approach of condom promotion in the pastoralist community of Borana was not well integrated into the cultural norms and values of the pastoralist community. The PEN-3 cultural health model indicates that HIV/AIDS communication in the cultural communities of Africa needs to consider the context on the ground, like the socio-cultural factors, hampering the use of condoms (Iwelunmor, Newsome &Airhihenbuwa 2014;

Cowdery, Parker & Thompson2010; Airhihenbuwa 2007a). In addition, the multiple domain model states that health (including HIV/AIDS) communication should consider the contextual factors in the community (Zimmerman, Christakis & Meltzoff 2007).The culture-centred approach to health communication calls for attention to dialogue and locates participants from within the culture being studied (Ambar et al 2009).Thus, there is a need to consider the cultural economic factors, market price of condoms, gender, and environmental factors in promoting condom use under the Borana pastoralists. Condom use under Borana pastoralists was affected by socio-cultural and religious/spiritual beliefs. The promotion thereof in the pastoralist community of Borana should be tailored to the contextual factors on the ground.

6.6.4 Political interventions in HIV/AIDS communication

The political system has an influential role to play within the healthcare system to prevent HIV/AIDS (Karan et al 2017). Karan et al (2017) states that the partnership between politics and the health system must continue to strengthen and leverage major change in behaviours and attitudes. The data reveals that local government leaders educate, inform, and communicate with the community on HIV/AIDS. However, the political leaders decide on the participants, content, and means of communication from the political perspectives. The government developed politically initiated artificial groups (one to five, a group of five people). The group formation was in line with the political interests. The participants, Tura Kurkura and Kayo Alake, reflected that:

> *The political Interests influenced HIV/AIDS communication. Local political leaders control HIV/AIDS conversations* (Tura Kurkura_Haro Renji kebele).

> *Health workers rarely organised free platforms to discuss HIV/AIDS. Politicians decide the content of HIV/AIDS communication. They also decide who participate in meetings. The report was also to address the political interests, not the reality of the problems* (Kayo Alake_Guto kebele).

> *HIV/AIDS communication in the rural area is not free from political intervention. Some health professionals have a political assignment. They try to persuade the community to accept health messages based on the government's direction. The local leaders are also forcing the community to accept what is being said by the politicians.*

> *The communication seems authoritarian, one-way, and persuasive* (Jaldesso Wayu_Haro Dimtu kebele). *HIV/AIDS communication in the community was not mandated by the interests of the health workers. Politicians mostly decide what to communicate and how to communicate. HIV/AIDS issues are discussed during meetings arranged by political leaders. Healthcare workers rarely organise their own stage for health issues such as HIV/AIDS information, education, and communication* (Abdi Tolcha_Guto kebele).

It is evident from the data that the HIV/AIDS communication approach and content was not free from political influence. The healthcare workers were not mandated to organise public forums concerning HIV/AIDS without the consent of the political decision makers. Community level meetings, including HIV/AIDS issues, were not free from political mission. However, political leaders should promote effective HIV/AIDS communication through activities such as contextualised public speeches as well as public forums (Abraar et al 2017). The political leaders' intervention with HIV/AIDS communication should be inclusive and encourage positive behavioural change. The cultural health model for Africa asserts that HIV/AIDS communication in the developing countries such as Ethiopia should be culturally driven. The communication approaches and message design should be culture friendly. Disseminating HIV/AIDS information, education, and communication materials alone cannot bring the positive behavioural change in the context of a culturally bound community like the Borana pastoralists. To curb the spread of HIV/AIDS, healthcare workers and the government bodies should not only give focus to the macro contexts such as politics and the economy, but they also need to consider the impact of the contextual domains in the community.

6.6.5 HIV/AIDS communication models being practised in the Borana pastoralist community

Behaviour change communication's main objective is to promote tailored messages, personal risk assessment, dialogue, and an increased sense of ownership. It is developed through an interactive process (with its messages and approaches), using a mix of communication channels to encourage and sustain positive and healthy behaviours (UNAIDS 2011). In the context of a collectivist culture, HIV/AIDS prevention should focus on the issues related to the socio-cultural, gender, and religious/spiritual context of the target community.

The behaviour change communication seemed overlook the home-grown contexts. The in-depth interview participants, Kayo Alake and Tura Kurkura, explained that:

> *The communication is with predetermined messages and behavioural change intention. The communication is just to convince people to accept the intended message. The communication is believed to bring individual behavioural change. However, practising the expected behaviour is poor* (Kayo Alake_Guto kebele).

> *HIV/AIDS communication is to convince the residents to prevent and control the epidemic. Individually oriented HIV/AIDS information, education, and communication are emphasised. Specific context is missing* (Tura Kurkura_Renji kebele).

The data indicated that HIV/AIDS communication models currently in practise were oriented to individual behavioural change. HIV/AIDS communication in the pastoralist community of Borana was influenced by the western model of behavioural change communication. The findings of Obregon (2000) reported that HIV/AIDS communication models in Africa are derived from the western behavioural change communication model, which overlooked the collectivist culture of Africans. Western-originated health theories such as behavioural change communication, the social marketing theory, social learning theory, and trans-theoretical model about health behaviour in Africa often frame problems as related to individuals' actions or inaction (Airhihenbuwa, Ford & Iwelunmor 2014). The data also indicates that HIV/AIDS communication in the Borana pastoralist community focuses on the general population, which undermines the specific context of the target community. To change negative health behaviours, one must first identify and promote positive health behaviours within the cultural and its context (Airhihenbuwa, Ford &Iwelunmor 2014). A culture-centred approach to health is about working from within a culture to identify the health issues that a community considers important (Dutta 2007). Therefore, a culture-centred approach to HIV/AIDS prevention, care, and support is increasingly recognised as a critical strategy (Airhihenbuwa & Dewitt 2004). HIV/AIDS intervention and communication strategies in the Borana pastoralist community should focus on cultural contexts to achieve meaningful and sustainable social behavioural change.

6.7 RELIGIOUS/SPIRITUAL DIMENSIONS OF HIV/AIDS COMMUNICATION

This theme is based on the conceptual framework of HIV/AIDS communication. It focused on tailoring HIV/AIDS communication to the religious/spiritual context of the Borana pastoralist communities.

This section of the thesis specifically presents religious/spiritual related data that HIV/AIDS communication among the Borana pastoralists should consider for its religious/spiritual appropriateness.

6.7.1 The role of religious institutions to promote HIV/AIDS communication

Religious leaders and those associated with faith-based organisations have the formidable task of speaking out truthfully and taking the necessary action to curb the spread of HIV /AIDS (Ochillo et al 2017). Religious institutions in Africa are trusted and respected institutions. Their strength and credibility, as well as their closeness to the communities, afford them the chance to make a real difference in halting the spread of HIV/AIDS. Any messages on HIV/AIDS imparted by religious leaders are expected to be important in changing the attitudes and the behavioural patterns of their followers (UNICEF 2014; 2003). Faith-based organisations have their own responsibility to develop societal health. UNAIDS (2001) argues that HIV/AIDS communication programmes should tap into the spiritual domain of human beings. HIV/AIDS deals with issues of life and death, care and compassion, as well as hope and support, which represent their core spiritual values. In Ethiopia, religious/spiritual orientation has an important obligation to inform, educate, and communicate good health. In the religious/spiritual practice-dominated community, overlooking the role of faith-based institutions to develop societal health would create significant gaps. However, the way religious figures perceive and recognise the health and health behaviours of a community has its own effect. The participants, Abdi Tusa and Hassan Ahmad, explained that:

> *There are different understandings about HIV/AIDS. Our church understands HIV/AIDS is because of our sin. Commercial sex work is against God's will. Extramarital sexual intercourse is against God's will. Polygamy is against God's will. Churches have the moral obligation to teach good behaviour* (Abdi Tusa_Mata Gafarsa kebele).

> *Religious institutions speak about good health. However, there are differences among the religious teachings. There are differences in the spiritual understanding among the followers of different religions, which create gaps in HIV/AIDS communication. The coordination among the institutions is also not strong enough to shape societal health behaviour* (Hassan Ahmad_Haro Dimtu kebele).

> *There is no similar understanding among people following different religions when it comes to HIV/AIDS. There are people who consider HIV/AIDS to be as simple as other viral disease, such as calf. There is poor collaboration among the religious institutions* (Gebeyehu Fekadu_Mata Gafarsa kebele).

It is evident from the data that the differences among the religious institutions concerning HIV/AIDS hamper the efforts to prevent the epidemic. The data further shows that there is a strong belief among some religious communities that HIV/AIDS is sent from God because of sin. The study by Shaw and El-Bassel (2014) reported that some religious communities consider HIV/AIDS to be a punishment because of sin. This belief negatively affects the HIV/AIDS message receptions, public promotion of condom use, and forms of sex education. The data shows that there were religious teachings that negate commercial sex work, extramarital sexual relations, and polygamy to prevent the spread of HIV/AIDS in the Borana pastoralist community. This agrees with Dilger et al (2010) who reported that some religious doctrine advice against polygamy, extramarital sexual relations, commercial sex, and alcohol to control the spread of HIV/AIDS.

Religious teaching helps to avoid polygamy and extramarital sexual relations that contribute to HIV/AIDS prevention in Africa (Sovran 2013). The influence of religious organisations is widely recognised as a key factor in the fight against the HIV epidemic, particularly in sub-Saharan Africa (Dilger et al 2010). However, the findings of this study revealed that coordination among the faith-based institutions and the health institutions were not strong. There is a need to coordinate religious institutions to collaborate in the prevention against HIV/AIDS. In Ethiopia, people are very loyal and obedient to messages conveyed by religious leaders. Religion has undeniably been a very potent motivator of behaviour and behavioural change throughout history (Sovran 2013). There is great opportunity to work with the religious institutions and religious leaders in the context of Borana to control the spread of HIV/AIDS. However, there is a gap regarding the integration of HIV/AIDS messages with religious teachings. In addition, religious misperceptions concerning HIV/AIDS were not properly tackled in the pastoralist community of Borana. The participants, Hassan Ahmad and Abdi Tusa, said:

> *Our religion never supports or encourages extramarital sexual intercourse. Health workers in the community are not effectively working with us* (Hassan Ahmad_Haro Dimtu kebele).

The church has the mandate to save lives and to develop both physical as well as spiritual well-being. Extramarital sexual intercourse is a sin. Both polygamy and commercial sex is a sin. Marriage without church knowledge is not acceptable and sexual intercourse before marriage is a sin (Abdi Tusa_Mata Gafarsa kebele).

Waaqaa (God) protects Borana. Marriage values are deteriorating these days. Sexual relations out of the cultural norms and values are not acceptable (Guyo Wako_Renji kebele).

It is evident from the data that the religious/spiritual values on extramarital sexual relations and polygamy is a powerful tool to help address HIV/AIDS messages. Shaw and El-Bassel (2014) reported that religious norms and values such as destiny, compassion, and purity have demonstrated promise in preventing HIV/AIDS risks. However, the data also shows that there were religious teachings that encourage polygamy in the Borana pastoralist community. This is not consistent with the findings of Sovran (2013) which concluded that religious teaching helps to avoid polygamy and extramarital sexual relations that contribute to the HIV/AIDS prevention in Africa. The data further indicated that the roles of faith-based institutions and/or religious leaders were not properly coordinated to curb the practices that fuel the spread of HIV/AIDS in the Borana pastoralist community. Thus, faith-based institutions in the pastoralist community, regardless of their doctrine differences, should have good coordination with the health institutions to promote positive religious values and practices to prevent HIV/AIDS. The PEN-3 cultural health model indicates that HIV/AIDS communication in the cultural community of Africa needs to consider the context on the ground like religious/spiritual beliefs and practices (Iwelunmor, Newsome & Airhihenbuwa 2014; Cowdery, Parker & Thompson 2010; Airhihenbuwa 2007a).

6.7.2 Faith healing as a barrier to HIV/AIDS communication

HIV/AIDS information, education, and communication can be affected by religious beliefs and practices (Mapingure, Mukandavire, & Chingombe 2021; Usadolo 2019). The influence of religion and belief systems is widely recognised as an important factor in understanding the health risk perceptions and myths in the fight against the HIV pandemic (Mapingure, Mukandavire & Chingombe 2021).In Africa, faith healing is taken for granted to protect, as well as cure, chronic diseases such as HIV/AIDS (Azia et al 2022; Oladimeji et al 2020; Moshabela et al 2017).Mapingure, Mukandavire& Chingombe(2021) and Mapingure et al (2021) reported that religious teaching and church regulations, for example faith healing,

negatively shape healthcare-seeking behaviour. Medical pluralism contributes to delays and interruptions of care along the HIV cascade, and mistrust between health providers. The participants, Gebeyehu Fekadu, Guyo Wako, and Hassan Ahmad, explained that:

> *Prayer, meditation, regular church services, and religious activities can prevent and control the spread of HIV/AIDS. Connectedness with God can save humankind from HIV/AIDS. The integration of religious institutions and health institutions to address HIV/AIDS information, education, and communication thus far is not adequate. There is no persistence in working together* (Gebeyehu Fekadu_Mata Gafarsa kebele).

> *There are people who believe that the Holy Spirit can cure HIV/AIDS. There are individuals who refrain from attending antiretroviral therapy (ART) due to religious beliefs. There are gaps among the religious teachings* (Guyo Wako_Renji kebele).

> *There are religious fathers who believe that the Holy Spirit can cure HIV/AIDS. There are religious leaders who believe holy water can cure HIV/AIDS. Such religious teachings may affect HIV/AIDS message reception* (Hassan Ahmad_Haro Dimtu kebele).

The data affirms that faith healing and traditional beliefs hamper HIV/AIDS prevention and communication with Borana pastoralists. It indicated that religious doctrines, such as the protestant religion, accept that the Holy Spirit can cure one from any disease including HIV/AIDS. Orthodox religion on the other hand, accepts holy water can cure one from any disease. Kloos et al (2013) reported that faith healing from AIDS through prayer and various other spiritual practices in Ethiopia has been associated with the widespread belief in both natural and supernatural causation of illness. In addition, Kloos et al (2013) reported that faith healing is widely followed in Ethiopia for the treatment of HIV-related illness because of the long history, prevailing illness perceptions, and religious beliefs. Such religious beliefs and practices of faith healing may affect HIV/AIDS message reception in the Borana pastoralist community. Thus, there is a need to consider these religious contexts that hamper effective HIV/AIDS communication and messages receptions.

There are different arguments on faith healing in Africa. Some faith healers in sub-Saharan Africa claim to have cured patients through spiritual practices alone (Musheke et al 2012). However, the study by (Kloos et al 2013) reported that none of these claims have been clinically confirmed (Kloos et al 2013).

The participant, Guyo Wako, said that:

> *Some people go for medical services/information only after trying the local means such as prayer, traditional medicine, religious belief, and practices. There are people who attend church, mosques, but still look for fortune-tellers. There are people who visit traditional healers and were cured from diseases* (Guyo Wako_Renji kebele).

The data indicated that traditional practices and religious beliefs were believed to prevent and/or cure HIV/AIDS in Borana pastoralists. Musheke et al (2012) reported that some faith healers in sub-Saharan Africa claim to have cured patients through spiritual practices. In addition, Ramachandran (2011) stated that faith healers in sub-Saharan Africa use a combination of faith healing and herbal treatments to cure HIV/AIDS. Thus, the use of traditional healing mechanisms and faith healing has a negative influence on HIV/AIDS message receptions in Borana pastoralists. The religious beliefs and traditional practices did not consider the medical aspects of HIV/AIDS prevention, care, and treatment. Healthcare workers need to work in coordination with the religious leaders to control the religious beliefs and practices that fuel the spread of HIV/AIDS. The multiple domain model states that health, including HIV/AIDS, communication should consider the contextual factors in the community, other than the biomedical factors (Zimmerman, Christakis & Meltzoff 2007).

6.8 HIV/AIDS COMMUNICATION: HEALTHCARE WORKERS PERSPECTIVES

This theme focuses on tailoring HIV/AIDS communication to the socio-cultural context of Borana pastoralist communities. Cultural-related data collected from health workers is presented below.

6.8.1 Linking HIV/AIDS communication with cultural opportunities

HIV/AIDS prevention and control necessitate adoption of culture-sensitive approaches, intervention designs, and policy reforms appropriate to the context of sub-Saharan Africa (Moshabelaetal 2017). The communication context should take into consideration the local context. The participants, Biftu Badhane and Liban Waqo, said that:

> *The local socio-cultural institutions such as the Gadaa, GumiiGaayyoo, and Qaalluu are vital to Borana. However, these institutions are not well utilised. Healthcare*

workers understand the importance of culture, but practise less when it comes to the application (Biftu Badhane_Mata Gafarsa kebele).

HIV/AIDS communication in our context focuses more on the medical knowledge. Health workers do not have the basic knowledge and skills of communication. The health curriculum doesn't focus on the issues of socio-cultural aspects in health communication (Liban Waqo_Mata Gafarsa kebele).

The data revealed that HIV/AIDS communication was not well integrated with the cultural symbols of the Borana pastoralist community. HIV/AIDS campaigns were less responsive to the Borana pastoralists' cultural context. Understanding the health behaviour of a community would help to facilitate health services properly (Short &Mollborn 2015). The data also revealed that the medical aspects of HIV/AIDS was emphasised. The integration between the epidemiological and socio-cultural aspects of HIV/AIDS communication was inadequate. This contrasts with the study by (Mabweazara, Ley & Leach 2018) which revealed that HIV/AIDS is both a biomedical disease and a social phenomenon that is constructed in specific cultural contexts. The data further indicated that the health curriculum in Ethiopia undermined contextualised communication. Uwah (2013) reported that health communication in Africa lacks adherence to the cultural norms of the target communities. Good communication is integral for health service delivery (Hawkins et al 2008). To communicate effectively, school curriculums need to expose health professionals to various aspects of communication in health services. Healthcare workers should understand the socio-cultural contexts, have good, contextualised communication skills and knowledge, and consider the health behaviour of the target community to address HIV/AIDS messages. Sexual education, including HIV/AIDS education, is a restricted culture. Health behaviour such as the decision to discuss HIV/AIDS freely and the decision to use condoms is affected by the cultural orientation (Short &Mollborn 2015). The participants, Biftu Badhane, Liban Waqo, and Tefera Gemeda explained that:

People fail to discuss personal illnesses in public. Even if one is fatally sick, it is common to hear that he/she may say, "I am okay." Such health behaviour affects the attention given to HIV/AIDS communication (Biftu Badhane_Mata Gafarsa kebele).

There are cultural practices that fuel the spread of the HIV/AIDS epidemic. Jaala-Jaaltoo is a culturally recognised extramarital sexual practice that affects HIV/AIDS communication (Liban Waqo_Mata Gafarsa kebele).

Polygamy is still practised in the community, but it is not just for sexual pleasure. This emanates from socio-economic and political interests (Tefera Gemeda_Guto kebele).

Culturally, girls are not expected to have sexual intercourse before marriage. Giving birth before marriage is taboo and culturally offensive (Tefera Gemeda_Guto kebele).

Like the cultural and religious leader's data, the above data affirms that talking about sex is a cultural taboo. *Jaala-Jaaltoo,* sexual networks, and polygamy create a challenge to communicate HIV/AIDS effectively. Social and cultural values, norms, and traditions influence HIV/AIDS prevention (Khandu, Tobgay & McFarland 2021). In addition, the data indicated that refraining from sexual intercourse before marriage and not giving birth before marriage were positive Borana cultural values and norms to curb the spread of HIV/AIDS. Pastoral communities in sub-Saharan Africa are characterised by traditional practices such as extramarital sexual relations, polygamy, and FGM (Van der Kwaak et al 2012). Extramarital sex is a potential driver of the human immunodeficiency virus (HIV) transmission for long-term couples in sub-Saharan Africa. The study by Mtenga et al (2018) reported that preventing sexual risk behaviours in a cultural society requires an understanding of the context right from the bottom. The study by Auerbach, Parkhurst & Cáceres (2011) reported that sexual behaviours and HIV vulnerability are deep-rooted within the broader social, cultural, economic, and political contexts. The health system should not only focus on blaming the harmful cultural practices, but also focus on utilising the positive cultural resources to avert the spread of HIV/AIDS. To curb the spread of HIV/AIDS due to religious/spiritual beliefs and practices, the communication approach should consider the contextual factors that either accelerate or decelerate the spread of the epidemic. In line with this, the PEN-3 cultural health model indicates that HIV/AIDS communication in the cultural community of Africa needs to consider contexts on the ground like religious/spiritual beliefs, perceptions, and practices (Iwelunmor, Newsome & Airhihenbuwa 2014; Cowdery, Parker & Thompson 2010; Airhihenbuwa 2007a).

6.8.2 Dealing with risky religious beliefs and practices to prevent HIV/AIDS

HIV/AIDS communication should address traditional practices and belief systems that may aggravate the spread of HIV/AIDS (Azia et al 2022; Oladimeji et al 2020; Moshabela et al 2017). Traditional healers, religious leaders, herbalists, households, and some drug retailers use a wide range of herbal treatments, as well as supplementary and palliative measures,

often in combination with faith healing pertaining to HIV/AIDS (Homsy et al 2004). Traditional ways, such as traditional beliefs and practices, to cure HIV/AIDS brings mistrust between health providers and the community (Moshabela et al 2017). The participants, Liban Waqo and Biftu Badhane, explained that:

> *There are religious people who hold polarised ideas and beliefs. They overlook the epidemiological aspects of disease prevention and control. There are also segments of the community who believe in traditional practices such as holy water, faith healing, traditional healing, and herbal medicine to prevent and control disease* (Liban Waqo_Mata Gafarsa kebele).

> *Some people do not give attention to the use of condoms. They believe condom use is against the word of God. Marriage in most cases occurs in the cultural settings, not in the religious contexts. The issue of condom use, blood tests for HIV/AIDS, and faithfulness may not be a concern* (Biftu Badhane_Mata Gafarsa kebele).

The data affirms that some religious teachings encouraged the use of holy water, faith healing, and herbal medicine to cure diseases.

This negatively influences HIV/AIDS education that promotes the use of condoms and other HIV/AIDS prevention measures like abstinence and being faithful to partners (Moshabela et al 2017). Healthcare workers need to collaborate with religious and cultural leaders to curb risky religious and cultural practices that discourage HIV/AIDS prevention strategies in the Borana pastoralist community. Positive religious values such as abstaining from sexual intercourse before marriage, faithfulness, avoiding adultery, or commercial sex can support HIV/AIDS campaigns. Some religious institutions disregard polygamy, sex before marriage, and alcohol use that has implications on preventing the spread of HIV/AIDS (Shaw & El-Bassel 2014). Religious organisations can play an important role in the fight against HIV/AIDS in sub-Saharan Africa (Dilger et al 2010). The participants, Biftu Badhane and Tefera Gemeda, said that:

> *People trust religious leaders and their teachings. However, there is a lack of persistence in coordinating religious institutions to curb the spread of HIV/AIDS. There is a lack of planning and strategic focus in using religious resources to curb the spread of HIV/AIDS. HIV/AIDS is purely a medical issue* (Biftu Badhane_Mata Gafarsa kebele).

Religious leaders have a different understanding and commitment in teaching about HIV/AIDS. They rely on prayer to cure disease. Most religious fathers believe in faith and spirituality, not science. Religious institutions are less open to secular education/teachings (Tefera Gemeda_Guto kebele).

The data revealed that religious resources including prayer, meditation, church services, and religious activities were not properly integrated into HIV/AIDS communication in the Borana pastoralist community. Religious teachings were also not properly integrated with health education to ban the spread of HIV/AIDS. Faith-based organisations have an important task of speaking out truthfully and taking necessary action to curb the spread of HIV/AIDS (Aja et al 2010). Listening to religious leaders can support HIV/AIDS prevention (Aja et al 2010). Healthcare workers should consider the religious/spiritual dimension of the target community for the proper design of messages. HIV/AIDS communication should properly utilise the positive religious resources and faith-based organisations to combat the spread of HIV/AIDS in the Borana pastoralist community. HIV/AIDS prevention in a collectivist culture should be tailored to the context in the local community.

6.8.3 A user-friendly HIV/AIDS communication approach

Cultural engagement in the HIV/AIDS communication is about participation. It is the inclusion of cultural attitudes, beliefs, norms, values, and assumptions that is critical to the success of the community's health (Hood, Campbell & Baker 2023).Engaging with culture means dialogue, working with channels of communication that are favoured and valued within a community, working within the "cultural logic" of that community, and supporting a community to define its own health solutions (Creative Exchange 2008). The cultural engagement includes the kind of sexual behaviours that are deemed acceptable. When people engage in sexual behaviours (and with whom) may be based on several factors, which include beliefs about sex, that can influence how relationships are defined, when and how contraceptives and condoms are used, who should decide about and communicate with partners about sex, and the expectations about personal responsibility for the consequences of these decisions (Wyatt et al 2012: 362).The way HIV/AIDS is communicated determines the intended behavioural changes towards HIV/AIDS. The participants, Biftu Badhane and Tefera Gemeda, said that:

HIV/AIDS communication is a top-down approach. The communication guideline is developed centrally. A positive practice to bring the behavioural change concerning

HIV/AIDS is lacking. The emphasis has shifted to Covid-19 prevention (Biftu Badhane_Mata Gafarsa kebele).

There is no proper HIV/AIDS communication approach specifically designed for pastoralists. The health system in general did not consider the pastoralists way of living. The communication is based on the national/regional guideline (Tefera Gemeda_Guto kebele).

HIV/AIDS communication in Borana overlooked the pastoralist communication context. The communication approach was generalised. It was unable to consider the specific communication culture of the pastoral community. The communication did not consider the informal communication networks in the community. Local channels of communication were not well utilised (Liban Waqo_Mata Gafarsa kebele).

The data revealed that HIV/AIDS communication in the Borana pastoralist community was top-down and hierarchal. There was a lack of designing a pastoralist-friendly HIV/AIDS communication approach that suits the mobile nature of the pastoralist community. The HIV/AIDS communication approach was the same as the approach for the non-pastoralist community (highlanders). Khandu, Tobgay, and McFarland (2021) reported that HIV/AIDS responses should be tailored specifically for key populations instead of the current generalised approach. The use of the right communication approach enhances effective health messages (Khandu, Tobgay & McFarland 2021). Therefore, culturally tailored communication would help to address HIV/AIDS messages properly in the Borana pastoralist community. HIV/AIDS communication seeks to understand diverse processes and effects, including how different channels and types of information can be mobilised instrumentally and strategically in domains such as public health (Storey et al 2014). Communication occurs at multiple levels such as intrapersonal, interpersonal, macro societal networks, and organisations (Storey et al 2014). Integrating communication with the context of the target audiences is crucial. The participants, Tefera Gemeda, Liban Waqo, and Biftu Badhane, reflected by saying:

Oral communication is dominant when addressing HIV/AIDS information, education, and communication. Interpersonal and group communication is effective in the collectivist cultural community, but it is not utilised and contextualised. The use of media technology is low among the pastoralist community (Tefera Gemeda_Guto kebele).

The use of public figures and cultural resources to communicate HIV/AIDS is inadequate (Liban Waqo_Mata Gafarsa kebele).

The Borana pastoralist community is not a high-tech cultural community (communication is not direct). Most messages are conveyed implicitly using folklore such as proverbs. The community is rich in oral traditions. Nevertheless, these resources are not integrated well into the HIV/AIDS communication. There is a lack of culture-specific communication approaches that address women pastoralist interests regarding HIV/AIDS (Biftu Badhane_Mata Gafarsa kebele).

Oral, face-to-face communication is a dominant channel of communication in the Borana pastoralist community. However, the data indicated that face-to-face HIV/AIDS communication in the Borana pastoralist community focused more on the formal communication channels organised by the government officials or healthcare workers. The communication channels were controlled and directed by the health workers/government cadres. Rogers et al (2021) reported that, regarding HIV/AIDS communication in rural areas, there is over-reliance on urban professionals and politicians as intermediaries between rural communities and development actors. The data also indicated that people in the urban areas and the public figures were more privileged to participate in HIV/AIDS conversation forums in the pastoralist community. Approaches to development, including HIV/AIDS communication, should emphasise the importance of community participation in planning and setting up a development agenda (Rogers et al 2021). The data further shows that HIV/AIDS communication was not supported by media technology, such as community radio, as an alternative medium for communication. Rather than relying on official HIV/AIDS conversation forums and meetings, healthcare workers in the Borana pastoralist community should look for alternative HIV/AIDS communication opportunities such as community and/or family conversations, community networks, coffee time discussions, community radio and mobile technology. HIV/AIDS communication should consider pastoralist-friendly media technologies such as community radio and mobile texts that would focus on the pastoralists' development programmes, including HIV/AIDS prevention. HIV/AIDS communication (message design, format, content, langue channel selection) among the Borana community should be relevant to the community and the pastoralists' livelihoods. Based on the notion of the PEN-3 cultural health model and the multiple domain model, HIV/AIDS communication in the cultural communities of Africa needs to consider the contexts on the ground, like user-friendly communication channels and approaches that suit the pastoralist way of life

(Iwelunmor, Newsome &Airhihenbuwa 2014; Cowdery, Parker & Thompson 2010; Airhihenbuwa 2007a; Zimmerman, Christakis & Meltzoff 2007).

6.9 CONDOM PROMOTION AMONG THE BORANA PASTORALIST

Due to the male-dominated culture, most women in Africa are at a high risk of HIV infection because of their inability to negotiate condom use, or to reject forced sex and non-consensual sex (Hamidi, Regmi &Tejilingen 2023; Madiba & Ngwenya 2017; Mpondo et al 2015; Ramjee& Daniels 2013). Cultural norms, economic constraints and religious issues influence the use of condoms (Jain et al 2018). The intention of condom promotion is not only to protect against unnecessary conception, but also unsafe sexual intercourse that exposes the sexual partners to HIV/AIDS (Akelo et al 2013). The participants, Biftu Badhane and Tefera Gemeda, pointed out that:

> *The pastoralist community never rely on condom use due to cultural and religious factors. Most community members do not want to speak the word "condom" because of the taboo topic of sex. Condom use is negatively interpreted from a cultural and spiritual point of view* (Biftu Badhane_Mata Gafarsa kebele).

> *Condom accessibility problems arise due to the mobile nature of pastoralists. Most people believe that condom use is about discouraging conception. Most rural women don't have the right to demand the use of condoms. Sexual decisions are up to the men (husbands). Some religious teachings do not support condom promotion, as it encourages sex before marriage* (Tefera Gemeda_Guto kebele).

> *Condom promotion is common, especially at health centres. Patients who visit health stations for medical cases are usually given health advice, such as condom use, to prevent HIV/AIDS and/or for family planning. There is also condom promotion using different printed products in the health stations. But the use of condoms is not widely communicated among the largest pastoralist community* (Liban Waqo_Mata Gafarsa kebele).

> *Condoms are not freely spoken of in the community. Rural people are not free to buy condoms. They are not free to ask for condom sat the health posts. There is cultural as well as religious/spiritual influence to use and/or talk freely about condom use* (Biftu Badhane_Mata Gafarsa kebele).

Like the cultural and religious leaders' data, it is evident that condom promotion and use in the Borana pastoralist community was hampered by the cultural, religious, gender, and economic factors (Hamidi, Regmi & van Teijlingen 2023; Madiba & Ngwenya 2017). The data also indicated that condoms were not adequately accessible to the pastoralist community. This agrees with the studies by Closson et al (2018) and Skovdal et al (2023) who reported that the lack of desire to use condoms, lack of local access to condoms; gender inequalities, and social norms restrict condom use in sub-Saharan Africa. Similarly, Evans et al (2018) reported that condom distribution problems and its cost affect the use of condoms in the low-income countries of sub-Saharan Africa. In addition, the data revealed that religious factors hampered effective use of condoms. The study by Shaw and El-Bassel (2014) stated that religiosity is associated with a lower acceptance of condom use in sub-Saharan Africa. In a cultural community such as the Borana pastoralists, condom use is a secret topic as it relates to sexual issues, which remains taboo. This is comparable to the study by Bastien, Kajula & Muhwezi (2011) which reported that the culturally taboo topic of sex and religious norms, as well as expectations affect open HIV/AIDS communication and condom use in sub-Saharan Africa. The data also revealed that Borana pastoralists have the desire to have many children, which creates suspicion around condom use. This is comparable to the study by Ahinkorah et al (2020) which reported that in sub-Saharan Africa there is a desire for many children, which influences the use of contraceptive devices such as condoms. Thus, cultural, religious, gender, economic, and accessibility factors affected condom promotion and use. HIV/AIDS communication and condom promotion strategies should consider the pastoralist context. Condom promotion alone cannot bring the intended behavioural change in the community. Factors out of the individual's control should be considered for effective use of condoms among the pastoralist population.

6.10 CONCLUSION

The study found that Borana pastoralists believe the HIV/AIDS pandemic is God's retribution for sin and can only be averted by prayer. Both, Etsub & Moyer (2013) found that most sub-Saharan African pastoralists deny HIV and do not respond to HIV/AIDS interventions. In-depth and focus group interviews found that HIV/AIDS communication in the Borana pastoralist community was not tailored to local contexts such as the pastoral livelihoods, mobility, droughts, climate, socio-cultural, religion/spirituality, gender, demographic, and environmental features. HIV/AIDS interventions in impoverished East African pastoralist populations were poorly contextualised and integrated (Serbessa et al 2016). Pastoralists'

views have been marginalised, which hinders the use of Indigenous resources to combat HIV/AIDS (Rogers et al 2021). Faith healing, herbal medicine, and fortune telling hindered HIV/AIDS communication in the Borana pastoralist community. The Holy Spirit and holy water were supposed to prevent and cure HIV/AIDS. *Jaala-Jaaltoo*, polygamy, FGM, widow inheritance, and drug usage (khat and alcohol) hindered HIV/AIDS communication and message reception among the culturally bounded Borana pastoralist community. The in-depth interviews and focus group interviews also revealed gender disparity in the pastoralist community, which led to harmful practices such as gender-based violence, early marriage, girls' school dropouts, migration, and commercial sex that solely exposed women to HIV/AIDS risks. Gender inequality and power relations diminish sub-Saharan African women's economic and social chances and encourage unsafe sexual activity (Mbonye et al 2012).

Health communication initiatives must include target audience geography (Ahmad 2012:18), just as the western behavioural change approaches including the health belief model, social learning theory, and social marketing theory that drove HIV/AIDS communication. The HIV/AIDS preventive and communication strategies in the Borana pastoralist communities have focused on individual behaviour change, ignoring their collectivist culture. Medical HIV/AIDS prevention was prioritised above artistic HIV/AIDS messages. From the findings of this study, it is evident that Borana health services ignored the pastoralists. HIV/AIDS messages were not matched to Borana oral traditions such as nonverbal language, symbols, artefacts, proverbs, dances, costumes, and songs of the pastoral community. Community resources can assist health communication (Wanyoike 2011). HIV/AIDS information, education, and communication materials lacked original language, contextualised examples, pastoralists' living experiences, and their culture. Posters, brochures, and pamphlets in health posts were inappropriate for the pastoralists' cultural backgrounds and literacy levels. The HIV/AIDS communication employed masculine vocabulary and ignored femininity. It was also generally not contextually appropriate.

Health services in the pastoralist community were generic and ignored their unique needs. Positive socio-cultural and religious resources in the Borana pastoral community were not successfully integrated into community-based HIV/AIDS communication, other than condemning detrimental beliefs and practices. Western HIV/AIDS preventive and communication strategies ignored Borana pastoralists' communal culture. According to the PEN-3 cultural health model and the multiple domain models, HIV/AIDS communication in Borana's cultural pastoralist community must address pastoral circumstances.

Lastly, this study also provides a culturally driven conceptual framework to prevent Borana pastoralists from contracting HIV/AIDS. For effective social behavioural change, illness prevention communication should follow the socio-cultural (religious/spiritual, language, norms, values, belief system, gender, user-friendly communication) path.

HIV/AIDS communication in the Borana pastoralist community was not properly tailored to the contextual domains in the pastoralist community. The health system and health service delivery in the pastoralist community was general and overlooked the specificities in the pastoral community. There were poor health facilities to deliver the necessary services as well. The positive socio-cultural and religious resources in the Borana pastoral community were not well integrated into the community-based HIV/AIDS communication. In addition, an HIV/AIDS prevention and communication approach in Borana was influenced by the western models of disease prevention. Basing the notion on the PEN-3 cultural health model and the multiple domain models, HIV/AIDS communication in the pastoralist community of Borana needs to consider the local contexts (Iwelunmor, Newsome & Airhihenbuwa 2014; Cowdery, Parker & Thompson 2010; Airhihenbuwa 2007a; Zimmerman, Christakis & Meltzoff 2007). Additionally, this study contributes a culturally driven conceptual framework to curb the spread of HIV/AIDS among the Borana pastoralists.

CHAPTER 7
PART II: FINDINGS AND ANALYSIS OF THE FOCUS GROUP DATA

7.1 INTRODUCTION

In this chapter, the data collected from the focus group interviews are discussed. The FGI data was collected from female households and male households in the Arero district of the Borana pastoralist community. The FGIs were used to explore the lived experiences of the participants pertaining to the socio-cultural appropriateness of HIV/AIDS communication in the target community. Part of the FGI data was compiled in the form of note taking, which were turned into a formal write-up after the interviews. The genders were separated to cater for community customs and for ease of communication. As discussed in Chapter 5, having groups that are homogeneous often allows participants to feel more comfortable discussing their experiences because their fellow group members have had similar experiences (Woźniak 2014; Cresswell 2009).Homogeneous groups also generate discussions of certain common issues and experience in a detail. Data from the different methods were triangulated to substantiate and validate the data accordingly. The qualitative data collected through the different sources like in-depth interviews, FGIs, and document analysis were corroborated and verified through the discussions of the findings in each chapter to enhance the validity and reliability of the results. This means the data triangulation during and across the discussions of the major findings facilitated the validation of data through cross verification. This chapter intended to address the following research questions namely:

- *Does HIV/AIDS communication among the Borana pastoralists address the socio-cultural domains such as culture, religion/spirituality, and gender?*
- *What are the social behavioural change practices among the Borana pastoralists in relation to the community-based HIV/AIDS communication?*
- *What is considered acceptable and culturally appropriate HIV/AIDS communication approaches for the Borana pastoralist community?*

The FGIs intended to explore the embedment of the socio-cultural contexts in the HIV/AIDS communication among the pastoralist community in Borana. Accordingly, socio-cultural contexts such as, religion/spirituality, gender, and communication approaches were the major themes that emerged from this study.

The different themes and sub-themes that were developed during the data analysis were discussed in relation to the objectives of the study. It was necessary to collect in-depth and first-hand information separately from the FGIs, as well as the male and female households in the Borana pastoralist community in their natural conversation style. This was done to understand the lived experiences of the target Borana participants regarding the socio-cultural appropriateness of HIV/AIDS communication. The FGIs helped to explore new areas where issues, such as the socio-cultural integration of HIV/AIDS communication, are not yet understood, properly identified, or explored in the real-life context (Beverley et al 2009). Data triangulation is the use of a variety of data sources, including persons from different segments of the community (cultural leaders, religious fathers, and healthcare workers) and a document (national HIV/AIDS policy of Ethiopia) in the context of this study (Denzin & Lincoln 2011:84). In this study, data sources namely: in-depth interviews, FGIs, and a document were used to explore and understand the embedment of the contextual domains like culture, religion/spirituality, gender, and user-friendly communication into HIV/AIDS communication from the perspectives of Borana pastoralists. The findings were corroborated and any weaknesses in the data were compensated for by the strengths of other data, thereby increasing the validity and reliability of the results (Denzin & Lincoln 2011:84). This study also used the notion of theoretical triangulation as different theories were used in the literature review to move the study forward. The theoretical triangulation was helpful to capture the complexity of real-world phenomena concerning the participants' experiences of the community-based HIV/AIDS communication. The use of a variety of data sources, theories, and methodologies gave adequate insights into the research problem (Denzin & Lincoln 2011).

7.2 BIOGRAPHICAL DETAILS OF THE PARTICIPANTS

The following section presents the biographical information of the female and male households who participated in the FGIs. As a rule, group participants should have similar experiences with, or knowledge of, the research topic (Woźniak 2014; Cresswell 2009). Homogenous FGIs participants can freely entertain their ideas on the subject under discussion. In Borana, women (wives) are not free to explain their views in detail in front of the men (husbands), due to the deep-rooted culture of male dominance. Women (wives) are also not free to explain the culturally taboo topic of sex in front of the opposite gender. As a result, the researcher separated the men from the women in the FGIs, to get detailed information concerning the topic under discussion. The biographical details of the FGI participants are presented in the following tables:

No	Names of the participants (pseudonyms)	Social/professional responsibility	Age	Place of residence
1	Lelo Gumi	Female household	54	Mata Gafarsa Kebele
2	Walate Goro	Female household	45	Mata Gafarsa Kebele
3	Alemi Rare	Female household	47	Mata Gafarsa Kebele
4	Bontu Hirko	Female household	38	Mata Gafarsa Kebele
5	Galate Wayu	Female household	40	Mata Gafarsa Kebele
6	Sara Hebo	Female household	55	Haro Dimtu Kebele
7	Tigist Yabu	Female household	57	Haro Dimtu Kebele
8	MisiradOdaa	Female household	48	Haro Dimtu Kebele
9	Gole Gabi	Female household	53	Haro Dimtu Kebele
10	Ribka Jaldessa	Female household	60	Haro Dimtu Kebele
11	Torbe Doyo	Female household	47	Guto Kebele
12	Guye Daga	Female household	52	Guto Kebele
13	Sora Tintano	Female household	39	Guto Kebele
14	Marge Guyo	Female household	38	Guto Kebele
15	TalileWariyo	Female household	55	Guto Kebele
16	Kolba Jirma	Female household	60	Renji Kebele
17	Foziya Hassan	Female household	41	Renji Kebele
18	Samira Abdi	Female household	37	Renji Kebele
19	Jamila Amza	Female household	47	Renji Kebele
20	Dureti Aga	Female household	58	Renji Kebele

Table 7.6 Biographical details of female FGI participants

No	Name of the participants (pseudonyms)	Social/professional responsibility	Age	Place of residence
1	Arero Guyo	Male household	61	Mata Gafarsa Kebele
2	Galgalo Boke	Male household	58	Mata Gafarsa Kebele
3	Alake Gumi	Male household	63	Mata Gafarsa Kebele
4	Mihiretu Tamiru	Male household	60	Mata Gafarsa Kebele
5	Boru Barak	Male household	44	Mata Gafarsa Kebele
6	Abdissa Nigatu	Male household	47	Mata Gafarsa Kebele
7	Guyo Niguse	Male household	56	Haro Dimtu Kebele
8	Garba Galessa	Male household	58	Haro Dimtu Kebele
9	Hassan Abdi	Male household	64	Haro Dimtu Kebele
10	Amza Ahmed	Male household	68	Haro Dimtu Kebele
11	Jawar Abdi	Male household	63	Haro Dimtu Kebele
12	Tura Kurkura	Male household	49	Guto Kebele
13	Gagna Kura	Male household	46	Guto Kebele
14	Gale Waqo	Male household	51	Guto Kebele
15	TotobaJaldessa	Male household	65	Guto Kebele

16	Gamada Wariyo	Male household	68	Guto Kebele
17	Sora Sororo	Male household	63	Renji Kebele
18	WariyoTintano	Male household	49	Renji Kebele
19	Aga Jarso	Male household	50	Renji Kebele
20	Malka Raga	Male household	66	Renji Kebele
21	Hirpho Alake	Male household	57	Renji Kebele

Table 7.7: Biographical details of male FGI participants

7.2.1 Female households

Female households who have a good understanding of the Borana culture and exposure to HIV/AIDS information, education, and communication participated in the FGIs. Twenty female research participants volunteered to participate in the FGIs, as per the selection criteria, although the proposed number was thirty. The number of female participants declined from 30 to 20 because of the serious problems created by Covid-19. Some female households did not accept the offer to participate in the group interview for fear of Covid-19. However, the research adhered to Covid-19 protocols such as social distancing and the use of a facemask when the interviews were conducted. Four (4) FGIs occurred with women. The number of female participants within each group was restricted to five because of Covid-19 challenges.

The number of focus group participants was determined by the nature of the topic, experiences of the participants, accessibility of the participants, and risk situations. The number of participants in FGI may be flexible in qualitative research due to different external factors such as risk situations, participants' availability, and volunteerism, nature of the topic, time, and space. Accordingly, it is possible to include five to eight participants in FGIs (Hadi & Muh 2020:145; Krueger 1998). In addition, adjustments made on the number of FGI participants during Covid-19 stated that the maximum FGI participants could be four to reduce unnecessary physical contact and secure ample physical space (Muhammad et al 2021). The government of Ethiopia also declared that four people could sit within a group, keeping the physical distance and taking the necessary Covid-19 precaution measures, such as wearing a facemask (Ethiopian Covid-19 Proclamation 3/2020). The age of the participants ranged from 37–60. The female participants provided in-depth data on HIV/AIDS communication, mainly from their socio-cultural perspective. The FGIs were conducted in the village residence of the participants, in the Arero district. It is common to conduct the interview in the natural setting of the participants.

The participants should be in a normal and familiar setting (Nyumba et al 2018). This is because the participants are more likely to be open and take part in the discussion if they felt more relaxed.

7.2.2 Male households

Male households who had an adequate understanding of the Borana culture and exposure to HIV/AIDS information, education, and communication participated in the FGIs. Although the proposed number of the research participants was 30, only 21 men volunteered to participate in the focus group interviews. The number of male participants declined from 30 to 21 because of the serious problems created due to the outbreak of Covid-19. Four FGIs were held to collect the data. The number of male participants within each group was restricted to four/five because of Covid-19 challenges. This was in line with the government of Ethiopia's Covid-19 regulation (Covid-19 Proclamation 3/2020) as explained above. The age of the focus group interview participants ranged from 46–68. The male participants provided in-depth data on HIV/AIDS communication, mainly from their socio-cultural perspective, which was included in the cultural HIV/AIDS communication framework for Africa (USAID 2000). The FGIs were conducted in their natural setting, in the district/village of the residents. The data was collected between the 10 February 2021 and 20 February 2021, partly using pen-and-paper interviews. The residual focus group interview data was taken in the form of note taking. The FGI participants from the community showed an informal way of interaction so that the researcher and his assistant systematically recorded the participants' answers relating to the research objectives. The FGI data was also taken in the form of note taking which were turned into a formal write-up after the interviews.

7.3 FOCUS GROUP DATA ORGANISATION

Audio-recordings during the FGIs were not consistent due to expressed discomfort by some of the study participants as well as the challenges imposed by Covid-19. Therefore, some participants of the FGIs were willing to give their ideas off the record. Some of the FGI participants were reluctant to share sensitive ideas and concerns about the sexual topic of HIV/AIDS publicly on the record. The researcher gave more focus to recording their answers through note-taking technique. In the context of Covid-19, some group participants were hesitant to even join the group for discussions. However, the researcher together with the assistant, tried to convince the participants to give their ideas concerning the research topic

without feeling restricted by the established FGI guideline, given some level of flexibility. The study by Self (2021) reported that during the Covid-19 pandemic, most researchers had to alter the way in which they collect data to keep themselves and participants safe, and to abide by government restrictions and laws. Alongside this, there has been an increased use of different modes to collect the data. This has initiated a conversation in academia concerning the choice of research modes to collect data in new ways. Although this conversation is not new, it has been central to interview-based research (Self 2021). Considering the Covid-19 protocol, the researcher was able to collect the data. The researcher and the research assistants were able to take quick notes during the interviews that were later elaborated into field notes. Field notes were translated into English and then into Afan Oromo to ensure data validity. The audio materials were transcribed into Afan Oromo and then translated into English. Before the transcription, the researcher repeatedly listened to the interview materials to internalise the data properly. Transcription is not a mechanical process where the written document becomes an objective record of the event. Written text varies from the spoken word in terms of syntax, word choice, and accepted grammar (Davidson 2009). The spoken words of the participants were changed into written texts; paraphrased and presented to suit the scientific paper language style. In some cases, some topics outside of the study context were discussed. The transcribers therefore must make subjective decisions throughout about what to include (or not), whether to correct mistakes and edit grammar and repetitions through repeated listening to the audio material (McMullin 2021). In addition, the notes were read and re-read to generate common themes and sub-themes in connection with the research questions. Themes and sub-themes were developed in relation to the research objectives and the theoretical framework using the manual approach (Lester et al 2020).

Following the development of themes and sub-themes, relevant statements, words, and expressions were put under the respective themes and sub-themes for analysis (Lester et al 2020).After completion of this process, the themes and sub-themes were printed and re-read to check consistency of the findings from the different sources. The transcription was aligned to the researcher's epistemological position and the guiding theoretical framework (McMullin 2021). The researcher worked from the assumption that people think what they believe and consider how they apply new information regarding the research topic. The epistemological position of the researcher helps to ascertain how the target research community make health decisions concerning the socio-epidemiological aspects of the HIV/AIDS epidemic. Meaning is socially constructed and subjective because of the subjective worldviews of the participants.

In this study, subjective interpretations of the findings were undertaken by answering the research questions without affecting the original meaning of the findings. Statements of the research participants were captured mostly in paraphrase form without mentioning names to ensure anonymity (Van den Hoonaard 2003:141). Thematic analysis procedures recommended by Lacey and Luff (2009) and Attride-Stirling (2001) was used.
Data from the FGIs was organised, transcribed, translated into English, arranged into themes, and then analysed and interpreted.

7.4 FEMALE AND MALE HOUSEHOLDS'DATA: RELATED TO THE CULTURAL, RELIGIOUS, GENDER, AND COMMUNICATION CONTEXTS OF HIV/AIDS

This theme is based on the guiding UNAIDS theoretical framework, the cultural framework of HIV/AIDS communication. The theme focused on tailoring HIV/AIDS communication to the socio-cultural, religious/spiritual, gender, and user-friendly communication domains. HIV/AIDS communication in Africa cannot be effective without due emphasis on cultural norms and values (Airhihenbuwa & Webster 2004). The outcome of HIV/AIDS communication is associated with the use of culturally sensitive communication, which includes the culture of the target community (Betancourt et al 2014).

In Africa, conventional public health awareness campaigns, focusing on only medical aspects, are largely unsuccessful at eliciting behaviour change where sexuality is concerned (Madlala & Khanyile 2023; Orukwowu et al 2022; Thiabaud et al 2020; Uwah 2013:141). In part, this is because behaviour patterns are not influenced by individual decisions, but rather deeply embedded within the cultural norms that are inherited (Uwah 2013). This shows that failure to acknowledge, respect, and work with the cultural positions held by community members can lead to cultural imposition, introjections, and symbolic violence, which undermine the pursuit of improved health (Bunn et al 2020). The impact of global health strategies to promote family and community well-being is severely constrained by the incongruity between critical facets of cultural context and global health practitioners' limited attention to the culturally grounded worldview of communities (Aubel & Chibanda 2022). Transforming global health programmes, including HIV/AIDS communication, is crucial to ensure cultural relevance of health messages.

7.4.1 Socio-cultural contexts in relation to HIV/AIDS prevention

Understanding the socio-cultural identities of the target community is part of the medical services. Many health practitioners in developing countries, however, uncritically impose the issue of biomedicine on the communities (Hahn & Inhorn2008). The cultural aspect of health communication was undermined in developing countries such as Ethiopia. As the central argument of this study, there is a need to address the socio-cultural aspects of HIV/AIDS for effective communication in the Borana pastoralist community in Ethiopia. Efforts to facilitate improved health should consider the ideas, priorities, and concerns that the members of the pastoralists attach to health. The inability to acknowledge the cultural values of the target community in health, including HIV/AIDS communication, undermines the pursuit of improved health (Bunn et al 2020).

In the context of health communication and disease prevention, culture is frequently perceived to be a negative factor in the health sector (Aubel & Chibanda 2022). Global health publications frequently refer to cultural barriers, obstacles, and constraints while ignoring positive cultural features (Aubel & Chibanda 2022). There is a need to incorporate, acknowledge, and respect the culture of the target community for effective health communication such as with HIV/AIDS in Africa. The cultural approach to health communication is important to treat health promotion through culturally embedded health messages and intervention as part of the cultural aspects of the target community (Wallerstein & Duran 2010). Health intervention in Africa should have culture as a priority factor in the design of its health communication programme (Uwah 2013:142). Culture is a crucial factor for Africa to address the problems of HIV/AIDS. This chapter presented data related to the socio-cultural contexts that HIV/AIDS communication among Borana pastoralists should consider for its appropriateness.

7.4.2 HIV/AIDS misperceptions: punishment, urban disease, male domination, female subservience

In sub-Saharan Africa, people have divergent views and misperceptions concerning HIV/AIDS. There is the belief that HIV/AIDS is due to God's punishment for people's engagement in sin or immorality (Azia et al 2022; Shaw & El-Bassel 2014; Mwamwenda 2013; Feresu & Smith 2013). HIV/AIDS is because of the disobedience of humans to the word of God concerning sexual oration and practices (Kopelman 2012; Du Toit 2012; Dete 2012). In addition, there has been deep-rooted misperceptions among the rural community of sub-Saharan Africa that the spread of HIV/AIDS is limited by factors like geography (for example: urban/rural, highland, lowland) and gender (for example: male/female) variations.

HIV risk misperception is associated with geographical as well as gender contexts which HIV/AIDS communication should consider (Cassels & Goodreau 2011). In addition, mobility due to the socio-economic impacts exacerbates HIV risks in developing countries within African (Shira et al 2012). The dominant patriarchal culture and society in sub-Saharan Africa exacerbates women's inferiority and their disparate health status, including exposure to HIV/AIDS risks due to factors like gender, culture, religion, and poverty (Ramjee & Daniels 2013). Economic marginalisation among women in sub-Saharan Africa forces them to be involved in transactional and multiple concurrent sexual relationships for survival (Choudhry et al 2015). Women in sub-Saharan Africa are disproportionately affected by the human immunodeficiency virus (HIV) due to socio-cultural, gender, power, and economic disparities (Mhungu, Sixsmith & Burnett 2023). Gender inequality, poverty, gender-based violence, and multiple sexual partners have contribution in the spread of HIV/AIDS in sub-Saharan Africa.

Understanding HIV/AIDS communication from the perspectives of the target community of the Borana pastoralists plays a significant role to prevent and control the spread of the disease. Misconceptions concerning HIV/AIDS issues can hamper the communication objectives of disease prevention and control. Misconceptions are a result of the interaction between individual and societal influences (Helleringer & Kohler 2007). Accordingly, misconceptions about HIV transmission are found to have a cultural undertone in sub-Saharan Africa (Sano et al 2016). In the context of a culturally bounded society like the Borana pastoralist community in Borana, Ethiopia, HIV/AIDS communication is influenced by the deep-rooted socio-cultural contexts. This is consistent with the study by Achen, Atekyereza Rwabukwali (2021), who reported that HIV/AIDS knowledge, beliefs, and attitudes are shaped by the cultural contexts of the target community. Cultural embedment of HIV/AIDS communication is essential to address the reality of the cultural community. The communication needs to consider the contextual factors to address user-friendly messages. The focus group participants reflected on different socio-cultural opportunities as well as bottlenecks to communicate HIV/AIDS issues in the community. The participants (female household_MataGafarsakebele and male household_HaroDimtu kebele) reflected on their misperceptions about HIV/AIDS saying:

> *HIV/AIDS is God's punishment. The disease was not in Borana culture. HIV/AIDS is the disease of the highlanders (urban). People who are getting older are not affected by the disease (sexual pleasure declines)* (Female household_Mata Gafarsa kebele).

> *HIV/AIDS is from God. It is simple for God. There is no need to get confused about medication for HIV/AIDS. It is all about praying and approaching God with a good heart. God's miracles are in various places. What is impossible for health professionals is possible for God.* (Male household_Haro Dimtu kebele)

The in-depth interview data in Chapter 6 (interviews with the cultural leaders) and the FGI data assert that some participants in the Borana pastoralist community believe that HIV/AIDS is sent from God because of sin. Dete (2012:2) reported that many people in sub-Saharan Africa are convinced that HIV/AIDS is God's punishment due to people's engagement in sin. However, some participants believe that HIV/AIDS is because of unprotected sexual intercourse. There has also been a perception among the Borana pastoralist community that HIV/AIDS does not attack the Borana due to *Waaqaa* (God)'s protection. Hartwig et al (2006) pointed out that in sub-Saharan Africa there is hindrance to HIV/AIDS prevention and intervention, which has been associated with faith organisations.
The study by Both, Etsub & Moyer (2013) also confirms that pastoralists in Ethiopia do not want to accept HIV and are therefore not responsive to HIV/AIDS interventions. In relation to this, the argument is that religious doctrines and societal beliefs have helped to create and support perceptions that those infected have sinned and deserve their punishment, thus increasing the stigma associated with HIV/AIDS. The idea that HIV/AIDS is a punishment from God is also based on the assumptions that extramarital sexual intercourse is sinful, that God causes suffering, and that God punishes sin with disease. These assumptions are based on a specific outlook on society, sexuality, as well as how God punishes ill practices. HIV/AIDS communication needs to consider the local perceptions about the disease for effective prevention. The FGI participants (female household_Renjikebele) stated:

> *Men (husbands) usually travel long distances to the livestock markets in towns. Men have more power to make decisions about issues related to finance, like selling livestock. In such cases, men stay in town for days. In addition, it is mostly the men (husband) who brings the disease to the pastoralist community from the towns* (Female household_Renji kebele).

The above feedback from the FGI participants further indicated that HIV/AIDS is seen as geographically restricted (the disease of the urban areas), which might negatively affect the effort to prevent HIV/AIDS in the rural community (Geliboet al 2022; Maulide et al 2021). Even though most of the population lives in the rural areas, the attention given to these

areas concerning HIV/AIDS prevention has been insignificant in Ethiopia. The rural communities have less HIV/AIDS awareness (Gelibo et al 2022). The findings are consistent with the study by Kloos (2013) who indicated that although the potential for an HIV/AIDS epidemic is high, and the prevalence rates are rising in the rural areas of Ethiopia, the rural community remain less informed and little research has been done on the nature of the disease in these areas. This finding is also corroborated by the study of Both, Etsub, and Moyer (2013) which reported that most pastoralists in sub-Saharan Africa doubt the existence of HIV and are therefore not responsive to HIV/AIDS interventions. Contextualised HIV/AIDS communication is required to clear doubt about HIV/AIDS and encourage message reception and practices towards positive social behavioural change.

In addition, this finding shows that there is a misunderstanding that elders are not subjected to HIV/AIDS problems. This misunderstanding was stated in the study conducted by Maes and Louis (2011) who reported that many older adults in sub-Saharan Africa do not consider themselves to be at risk of HIV and perceive it as an illness for younger people. This perception emanated from the declining sexual interest by the elders. There have been misperceptions about HIV/AIDS because of the deep-rooted socio-cultural and religious influence. After more than three decades of HIV/AIDS education, the pastoralists did not have adequate knowledge about HIV/AIDS. A perception gap continues to influence community understanding towards HIV/AIDS. This perception gap was also stated in the study conducted by Asgaryet al (2013) which reported that there was misperception among individuals, families, and communities in Ethiopia regarding HIV/AIDS and its spread. As a result, there is a need to improve individual and community knowledge and to reduce misconception about HIV/AIDS. A cultural approach tailored towards a specific cultural society, such as the Borana pastoralists, emphasising primarily local community initiatives, is warranted (Asgary et al 2013). The communication strategies that are used to influence HIV/AIDS risk perception and motivate behavioural change should be culturally appropriate. HIV/AIDS communication, education, and information should be suitable to the lifestyle and context of the pastoralist community in Borana.

The data shows pastoralist men (husbands) are more mobile. Men are expected to travel to towns for different purposes. Livestock marketing is a culturally assigned role of men. As a result, pastoralist women (wives) in the rural areas usually perceive that men (husbands) are more responsible for the spread of HIV/AIDS among the community. Mobile pastoralist men (husbands), travelling to a livestock market, were considered responsible for HIV/AIDS spread in the pastoralist community.

This misperception would make the women (wives) more reluctant and less responsible to prevent the spread of HIV/AIDS. This is consistent with the study by Mswela (2009:175) which reported that in Africa, multiple sexual partnerships are encouraged for men, while women (wives) are expected to be monogamous and unquestioning of their husband's behaviour which facilitates the spread of the virus. This is also confirmed by Van Staden and Badenhorst (2009) who reported that male dominance in Africa influences the sexual behaviour of women (wives) and places them at risk. As do cultural practices such as the men's view on perceived masculinity, which also increases their risk of contracting the HIV infection. Though there is gender-based discrimination, Borana pastoralist women (wives) blamed men (husbands) for the spread of HIV/AIDS in their community. However, the misperception should be corrected. Both pastoralist men (husbands) and women (wives) should feel responsible for the spread of HIV/AIDS as well as prevention in their community. This is possible through gender-inclusive HIV/AIDS education, information, and communication that equally empower both men and women in the community-based HIV/AIDS prevention strategies. In line with this, the FGI participants explained that:

> *Women (wives) don't have the right to investigate with whom her husband could have sexual intercourse. They don't have the right to request an HIV/AIDS test, even after confirming that her husband had sexual contact with someone else. Women (wives) are more engaged in reproductive work. Men (husbands) are more responsible for the spread of HIV/AIDS in this community* (Female household_Renji kebele).

> *Wives and husbands do not freely talk about HIV/AIDS; the issue is a taboo topic. However, men (husbands) have more freedom to talk about sexual issues including HIV/AIDS. Children are not free to talk about sexual topics within family settings. The community does not use plain language (clear expressions) when talking about sexual matters* (Female household_Renji kebele).

> *Borana women (mothers) advise their daughters on sexual issues in secret. Similarly, Borana men (fathers) advise their sons on sexual issues. Women have no freedom to talk about sexual matters in the public. Women who talk about sexual issues in the public sphere may be considered as someone who is against the cultural norm. Such action is considered a deviation from the norm* (Female household_Renjikebele).

Women's voices are less heard in the public sphere. A woman's key role is indoors. They are not expected to take part in social affairs like men. Mothers talk about HIV/AIDS issues with their daughters in secret. Fathers may do the same with their sons (Female household_Guto kebele).

Men have more accessibility to media information about HIV/AIDS. Women usually get less chance to participate in the public meetings concerning HIV/AIDS. Women rarely argue and discuss HIV/AIDS in the public forum. Women are silenced by the culture (Female household_Haro Dimtu kebele).

As the healthcare workers data explained in Chapter 6, this data also confirms that pastoralist women (wives) have no equal rights concerning decisions about sexual issues. Men (husband) were given the right to make sexual decisions. Gender roles and high-risk sexual behaviours underlie the HIV/AIDS epidemic (Jacques-Aviñó et al 2019). The gender roles are dynamic, context-specific, socially constructed, and influences how men interact with their sexual partners (Mswela 2009). The above data (like the findings of the in-depth interviews discussed in Chapter 6) also indicated that pastoralist men were considered as productive (play active roles in wealth accumulation) while the women were considered as dependent and voiceless, not only on the resource equity but also on deciding their sexual interest. In Africa, traditional roles of men were characterised by the belief that men were the primary breadwinners and superior to women (Calton et al 2014). HIV/AIDS communication should properly address the progressive beliefs about gender roles in support of gender equality so that HIV/AIDS communication could promote equal gender participation in HIV/AIDS prevention. The participants (female household_Guto kebele and female household_Renji kebele) said that:

Sexual decisions are up to the men (husbands). Having sex (sleeping with someone) is the decision of the men (husbands), although the women (wives) have no interest. The culture gives a better position to men (husbands) than women (wives) (Female household_Guto kebele).

Having sex (the participants used indirect expressions) is mainly the decision of the men (husband), whether the women (wives) are sexually interested or not. The culture gives men more freedom concerning sexual decision, choosing sexual partners, and travelling long distances to livestock markets. Women are more engaged in the reproductive work, which limits their movements to indoor activities.

As a result, men are considered more responsible for the HIV/AIDS spread in the community (Female household_Renji kebele).

Some FGI participants revealed that the spread of HIV/AIDS among the pastoralist community of Borana was more attributed to the men (husbands). In line with the findings of the in-depth interviews of the cultural leaders (Chapter 6, section 6.4), the above FGI data indicated that there is a misperception among some pastoralists that HIV/AIDS is an urban concern. There is a misunderstanding among the participants that HIV/AIDS is not an issue in the pastoralist community because of their deep-rooted, socio-cultural, and religious/spiritual beliefs and perceptions. Some women in the pastoral community perceive that HIV/AIDS is a man's concern. Considering men to be the main cause of the spread of HIV/AIDS in the pastoral community might affect women's (wives) perceptions of HIV/AIDS sources. This misunderstanding is confirmed by the UNAIDS Communication Framework (2000) and PEN-3 cultural approach to communication (Airhihenbuwa 2007a, 1995), which reported that HIV/AIDS communication in developing countries within Africa overlooked the embedment of the contextual domains such as culture, which encompasses gender issues. The study by UNAIDS (2013:4) also reported that gender inequalities and gender-based abuses and violence in Africa affected the capacity of women and girls to protect themselves against the spread of HIV/AIDS. Pastoralist women perceive that they were more susceptible to the problem of HIV/AIDS due to their husband's mobility.
The study by Morton (2006:7) identifies:

"The susceptibility factor of pastoralists which is related to their mobility, a typical feature of their livelihood, includes not only migration of families and herds in search of water and pastures, but also migration by men alone for marketing and non-pastoral labour, particularly to population centres. A high degree of sexual networking (polygamy, multiple sexual partners) is reported as traditional practice in some pastoralist groups."

Because of the pastoralists' livelihoods and mobility nature (as discussed in Chapter 6, section 6.4.1) social services outreach, such as health services, among pastoralists in the lowland areas of sub-Saharan Africa is scanty (Waters-Bayer, Birmeji& Mengistu 2005:1). Accordingly, HIV/AIDS prevention care and control is minimal in these areas (Waters-Bayer, Birmeji & Mengistu: 5). Male and female pastoralists in Borana do not have equal rights, including sexual decisions due to the gender gap. Andrew et al (2007) reported that Borana pastoralists remain highly male dominated, with women playing an insignificant role in the

processes of sexual decision-making, regulation, and control over resources. Mobile male pastoralists (husbands) had the opportunity to decide both on sexual and resource rights over women (wives). This exposes women to the danger of HIV/AIDS. The Borana pastoral community encounters risks of HIV/AIDS due to gender misperceptions that discourage females' participation to prevent HIV/AIDS (Kaba, Ame & Mariam 2013). In addition, the mobile nature of pastoralists had its own contribution to the spread of HIV/AIDS. This is in line with the study by Weinreich and Benn (2004:22) who reported that many poor countries of the world have people who, for varying reasons, are very mobile. As a result, mobile populations have an increased risk of HIV infection. HIV/AIDS communication in pastoralist areas should address gender contexts and consider the mobile nature of the target community through contextualised and participatory communication approaches.

7.4.3 Sexual networks, community health decision, forced early marriages, widow inheritance, and female genital mutilation

Sexual health behaviours and decisions in sub-Saharan Africa are influenced by individual, interpersonal, family, community, and contextual factors like culture, religion, and gender (Yeboah et al 2022). In sub-Saharan Africa, there are people involved in risky sexual behaviours, such as early sexual debut, widow inheritance, early marriage, inconsistent or non-use of condoms, and intergenerational sex (McCloskey 2021). In most African communities, cultural norms permit multiple sexual partners (Shelton 2009). Multiple sexual partnerships and unsafe sexual networks fuel the spread of HIV/AIDS in sub-Saharan Africa (Yeboah et al 2022). Multiple sexual partnerships have been found to be associated with high risk of contracting HIV/AIDS in sub-Saharan Africa. Sexual networks (partnerships) consist of a set of individuals or groups (nodes) connected by a variety of links that represent interactions which includes sexual relations enforced by culture, friendship, and money. This means sexual networks in sub-Saharan Africa can be seen in terms of sex workers, clients of sex workers, or the general population who are under the cultural influence of sexual networks (Helleringer & Kohler 2007). In the HIV/AIDS epidemic of eastern Africa however, infections within maintenance networks (networks of sexual relationships among low-risk individuals), account for most new HIV cases (Rapaportet al 2023; Ssebunya et al 2019; Helleringer& Kohler 2007).

There are factors such as the practice of polygyny (i.e., a man having multiple wives) that contribute to concurrent sexual relationships (Damtie et al 2021; Lawson & Gibson 2018; Reniers & Tfaily 2012; Eaton, Hallett & Garnett 2011).

In some cultures of sub-Saharan Africa countries, it is not unusual for women to have concurrent partnerships, although their secondary relationships generally may involve fewer partners, longer relationship durations, and greater secrecy than men (Kenyon et al 2020). It is vital to consider culturally rooted sexual partnerships (networks) that exasperate the spread of HIV/AIDS. HIV/AIDS communication should consider the centrality of local contexts such as culture, religion/spirituality, and gender to tackle the problems of multiple sexual partnerships, and/or concurrent sexual relationships, and polygamous sexual relations that contribute to the spread of HIV/AIDS in a rural community such as the Borana pastoralists (Khandu, Togbay& McFarland 2021; Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa 2007a).

There are harmful cultural practices in sub-Saharan Africa that negatively affect societal health such as FGM, extramarital sexual relations, substance abuse and early marriage (Kassew et al 2023; Endalamaw et al 2021; Abate et al 2018). These harmful traditional practices (see the findings of the in-depth interviews in Chapter 6sections, 6.4.5) include extramarital sexual relations, polygamy, community-based cultural decisions forcing early marriage, FGM, forced marriage, and the various taboos or practices which expose women to health problems (Uwah 2013). The FGIs as well as in-depth interview data indicate that traditional harmful practices among the Borana pastoralist community remain a challenge to curb the spread of HIV/AIDS. These traditional practices are all consequences of the insignificant value placed on women by their respective communities. They persist in an environment where women and girls have unequal access to education, wealth, health, and employment. Sexual and reproductive rights of women are widely violated and abused in Africa, partly because of numerous gender-based cultural and traditional practices. All these practices exist to varying extents in many African countries (Mubangizi 2015). Traditional sexual related affairs have a gender dimension in which women can be more exposed to extramarital affairs and HIV infection based on various gender dynamics including women's economic hardship, social beliefs, and masculinity norms (Mtenga et al 2018).HIV/AIDS communication should consider the cultural dimension and traditional practices that expose women to the problem of HIV/AIDS.

Bringing a cultural approach into HIV/AIDS communication allows prevention efforts not to rely solely on the import of foreign and biomedical concepts as means of prevention, but also to utilise Indigenous knowledge systems for sustainable and appropriate health programmes and prevention efforts while tackling traditional practices (Uwah 2013). A cultural approach offers a chance to improve the effectiveness of an HIV/AIDS communication strategy and

rebuild the trust of communities through more sensitive modes of engagement. A cultural approach allows HIV/AIDS prevention and care methods to come from within the culture (Somma & Bodiang 2003:19).

In addition, gender inequalities and power relations in sub-Saharan Africa reduce economic and social opportunities for better lives among women and increase risky sexual behaviour (Mbonye et al 2012). The in-depth interview data (Chapter 6, section 6.4.5.3) and the focus group interview data indicated that cultural practices such as *Jaala-Jaaltoo* sexual networks (see Chapter 6, section 6.4.5.3) had a negative influence in addressing HIV/AIDS messages effectively. The sexual networks such as *Jaala-Jaaltoo*, polygamy, widow inheritance (as the in-depth interview data indicated) (see Chapter 6, section 6.4.5.1), hampered HIV/AIDS communication among the Borana pastoralist community. These sexual partnerships (sexual networks) were not properly tackled because of their socio-cultural, gender, and religious bases. There is a need to tailor HIV/AIDS communication to ban such traditional sexual practices using a bottom-up and participatory approach of community-based HIV/AIDS prevention programmes. In addition, the existential nurturers of Africa's extended family/collectivist culture, and the negative nurturers of families (for example FGM), marriages (for example forced arranged marriages of young girls), late-night celebrations, widow inheritance, culturally recognised extramarital sexual intercourse, and early marriage has its own influence on HIV/AIDS communication. Girls who marry early are more likely to be beaten or threatened by their husbands than girls who marry later. Regarding the cultural practices such as *Jaala-Jaaltoo* that fuel the spread of HIV/AIDS, women are more likely to describe their first sexual experience as forced. In such cases, women have no sexual freedom and rights to protect themselves from HIV/AIDS because of male domination in sexual decisions.

The attempts to address the cultural practices (such as *Jaala-Jaaltoo)* that fuel the spread of HIV/AIDS in the Borana pastoralist community by means of health communication, was not adequate. The communication did not convince the community to ban such sexual networks that expose the pastoralist community to unsafe sexual intercourse. The communication did not tackle the community beliefs that *Jaala-Jaaltoo* strengthens social and economic ties among the pastoralist community. High-risk sexual behaviours such as *Jaala-Jaaltoo* are entrenched within the broader social, cultural, economic, and political contexts (Auerbach, Parkhurst & Cáceres 2011). This is in line with the study by Thornton (2009) indicating that in Africa, sexual liaisons with multiple partners is believed to increase the size and diversity of an individual's sexual and social network and therefore increases their social capital.

On a larger social scale, sexual networks may give individuals better access to some social and economic goods. Therefore, there should be contextually adapted information to address the extramarital affairs such as *Jaala-Jaaltoo* sexual networks (Mtenga et al 2018). The focus group participants, (male household_HaroDimtu kebele, male household_MataGafarsakebele and male household_Renji kebele) pointed out that:

> *There is Jaala-Jaaltoo sexual relations in the community. Men have Jaalaa and women have Jaaltoo. Jaala-Jaaltoo sexual relations is believed to enhance one's social recognition and public image. A wife might have several Jaaltoo. Similarly, a husband may also have a greater number of Jaalaas. It is the men who usually goes to the house of the home-seek husband (husband who stayed away from his home for sometimes) to have sexual intercourse with the wife. If the husband comes across that, there is a spear at the gate of his house. This signals that there is someone inside with his wife. Once the husband identifies (face to face) that someone is sleeping with his wife, the case is normally brought to the cultural leaders to decide* (Male household_HaroDimtu kebele).

> *There is Jaala-Jaaltoo sexual relations. Jaala-Jaaltoo is beyond sexual relations. It is part of social pride and a source of income* (Male household_Mata Gafarsa kebele).

> *Marriage is arranged by the family without considering the issues of HIV/AIDS. There is also early marriage, as girl's education was not properly recognised among the pastoral community. Decisions concerning societal affairs are made communally, within the circle of culture. Communal decision in Borana is facilitated by the cultural leaders (Gadaa father)* (Male household_Renji kebele).

These participants indicated that harmful practices such as *Jaala-Jaaltoo* and early marriage are still practised among the Borana pastoral community. Like the data from the in-depth interviews (Chapter 6), the FGI data revealed that *Jaala-Jaaltoo* sexual network was considered a positive cultural practice, regardless of its drawbacks in exposing the community to HIV/AIDS risks. Like the in-depth interview data suggested (Chapter 6, section6.4.5.3) the FGI data indicated that the sexual networks like *Jaala-Jaaltoo* is considered to have positive values among the Borana pastoralist community. This agrees with the study by Hofstede, Hofstede & Minkov (2010) which reported that sexuality is partially predetermined by a culture, which is socially learned at family level, one's neighbourhood, and the community.

The health communication did not adequately challenge such deep-rooted cultural perceptions and practices. HIV/AIDS communication among Borana pastoralists should consider the health problems of *Jaala-Jaaltoo* sexual networks. This is possible by applying continuous, but user-friendly, HIV/AIDS communication approaches that work towards tackling such harmful practices that fuel the spread of HIV/AIDS.

The role of health communication in sub-Saharan Africa has not been conceptualised systematically, that means the idea of health communication was not well recognised and integrated into the health system to promote public health (Storey et al 2014). As the document analysis data concerning the national HIV/AIDS policy of Ethiopia indicated (Chapter 8): communication in health policy was considered an affix (add-on task), which undermined the key roles of strategic and contextualised communication in the healthcare industry. However, it is crucial to realise that communication is part of healthcare. Health communication, including HIV/AIDS communication, need to thoroughly address the communication interest of the community through participation. This means HIV/AIDS communication and message design should use the socio-cultural and religious resources, including Indigenous institutions and the opinion leaders through the bottom-up approach of health communication. Pastoral communities are characterised by early sexual debut and early marriage which exposes them to negative reproductive health outcomes, such HIV (Achen et al 2021). The coordination and collaboration among health workers, opinion leaders such as cultural leaders, religious leaders, and the community at large, is crucial to tackle the harmful cultural practices such as *Jaala-Jaaltoo* sexual relations, polygamy, forced early marriage, and FGM that expose the community to the risks of HIV/AIDS. This is consistent with the study by Wanyoike (2013) which reported that culture should be positioned in the foregoing as a major factor in the various ways that HIV/AIDS has influenced the African population. It is important that HIV/AIDS communication among the Borana pastoralists should consider culture as a priority factor in the design of HIV/AIDS communication programmes.

Like the in-depth interview data (Chapter 6, section 6.4.5.2), the FGI data revealed that widow inheritance was among the cultural practices that threaten the health of the Borana pastoralist by increasing their risk to HIV/AIDS. Widow inheritance, together with *Jaala-Jaaltoo* sexual networks, contributed to the HIV/AIDS spread among Borana pastoralists. The FGI (female household_Haro Dimtu kebele, male household_Haro Dimtu kebele and male household_Mata Gafarsa kebele) pointed out that:

The wife of a deceased husband is inherited with the recognition of the community leaders. Someone from the clan can inherit the widow with the consent of the cultural leaders. A wife is inherited to manage the resources of the deceased husband. Widow inheritance is also a means to have extra children and resources. There is no culture of testing for HIV/AIDS prior to widow inheritance (Female household_Haro Dimtu kebele, Male household_Haro Dimtu kebele).

Widow inheritance is being challenged these days. Some religious doctrines disregard polygamy, extramarital sexual intercourse, as well as widow inheritance. However, in the practice of widow inheritance, there is no culture of HIV/AIDS testing before sexual engagement. The decision to inherit the wife of the deceased husband is up to the men (husbands). The formal wife may not have a say or reject her husband's decision to inherit someone's wife (Male household_Mata Gafarsa kebele).

The participants indicated that widow inheritance has been in practise among the pastoralist community. The intention of widow inheritance was not primarily for sexual pleasure, but rather a way to preserve the resources of the deceased husband within the clan. The clan is responsible to manage the resources via the widow inheritance cultural principle. The study by Sovran (2013:3) also reported that widow inheritance is usually by a brother of the deceased husband and helps to maintain the social and economic welfare of widows and orphans. In addition, the study by Mabumba et al (2007:4) indicates that through the culture of widow inheritance, the family of the deceased husband may desire continued control over the widow and the dowry, as well as any wealth accumulated by the deceased husband. After interpreting the responses from the FGIs, it is evident that in the contexts of the Borana pastoralists the practice of widow inheritance did not consider the hazards of HIV/AIDS because of the cultural importance of widow inheritance. The cultural principle outweighs the fear of HIV/AIDS. This is compatible with the study by Sovran (2013), which reported that widow inheritance has been implicated in the spread of HIV/AIDS because it encourages the formation of extended sexual networks. The data reveals that there was evidence of polygamy where people had no HIV testing before marriage. An educational approach to avert HIV/AIDS risks in Africa did not consider the pastoralist cultural context and way of life (Kenea 2019). There is a need to integrate HIV/AIDS communication with the cultural context to avert the challenges of widow inheritance among the Borana pastoralists. Widow inheritance in Africa is linked to the spread of HIV/AIDS because it encourages the formation of extended sexual networks (Nyindo 2005).

Such sexual practices among the Borana pastoralists should be tackled with participatory communication, such as community conversations, where the local people can clearly understand the health risks of widow inherence.

Though it remains a challenge, Ethiopia has committed to eliminate FGM and early marriage by 2025 (WHO 2017). The Ethiopian Ministry of Health banned FGM in all public and private medical facilities in the country. Medical personnel who engage in any form of FGM in medical facilities will be subjected to legal action (Aaba 2013). It is argued that FGM is a violation of the human rights of girls and women (WHO 2017). However, cultural practices and the misperceptions remain a challenge in the effort to ban FGM. The FGI participants (female household_Renji kebele and female household_Guto kebele) stated that:

> *FGM happens in the rural community. The practice is not public. Female genital mutilation is supposed to discourage early marriage due to sexual alertness. A female who is not circumcised at an early age is assumed to be disrespectful and disobedient* (Female household_Renji kebele).

> *The practice of FGM is done in secret. The practice is mostly carried out by traditional circumcisers* (Female Household_Guto kebele).

It is evident from the data that FGM remains a challenge to ban the spread of HIV/AIDS. The community did not consider its associated effect on the spread of HIV/AIDS. FGM, which involves the alteration of the female genitalia for non-medical reasons, is prevalent in sub-Saharan Africa, associated with long-term health complications, and HIV transmission (Monjok, Essien & Holmes 2007:33). Like the data from the in-depth interviews (Chapter 6), the above responses confirmed that there are cultural misperceptions regarding FGM; as it is acceptable in the community. This is in line with the findings by Sovran (2013) who states that female genital mutilation is culturally practised to discourage early sexual intercourse. This is inconsistent with the study by Van der Kwaak et al (2012) which claims that pastoral communities are characterised by early sexual debut, early marriage, and the prevalence of potentially harmful traditional practices such as polygamy and female genital circumcision. Although there were no FGM practices in official health posts, traditional circumcisers continued doing FGM in secret, during night times, especially in the rural areas in favour of the cultural expectations. HIV/AIDS communication and message delivery among Borana pastoralist to date did not bring the intended behavioural challenge regarding FGM.

The health extension workers did not convince the community concerning the health impact as well as HIV/AIDS related problems of FGM.

The top-down communication approach did not strategically address the risks of FGM. A participatory and bottom-up approach to HIV/AIDS communication that engages the pastoralist community and its cultural resources are vital to tackle FGM. As the national HIV/AIDS policy document analysis (Chapter 8) indicated, the lack of pastoralist-specific policy and strategy on issues such as HIV and FGM further complicates the problems of HIV/AIDS (Omar & Mohamed 2006:27). FGM is related to different issues such as health rights, culture, and legal and ethical aspects that need community specific policy intervention (Little 2003:30). There is a need to integrate HIV/AIDS communication with the contextual domains so that the target pastoralist community would support the government efforts to ban harmful practices such as FGM that contributes to the spread of HIV/AIDS in Borana (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa 2007a; Zimmerman, Christakis & Meltzoff 2007).

7.5 GENDER CONTEXTS: INVOLVING WOMEN IN THE COMMUNITY-BASED HIV/AIDS COMMUNICATION

Gender inequality and men's perceived sexual and economic superiority over women are central to human immunodeficiency virus (HIV) infections in Africa (Klaas et al 2018). In sub-Saharan Africa, gender norms put men in a position of sexual dominance that gives them sexual superiority and limit women's ability to control their own reproductive and sexual health (Pulerwitz et al 2010). The findings in Chapter 6, section 6.5 indicated that gender-based discrimination and power imbalance among the pastoralist community expose especially women to the risks of HIV/AIDS. Gender-based power dynamics frequently result in women having less power than men in sexual relationships in sub-Saharan Africa. Women often cannot negotiate protection, including condom use, and have less say over the conditions and timing of sex—factors that put them at a disadvantage in terms of HIV/AIDS risk (Pulerwitz et al 2010).This theme is based on the guiding notion of the PEN-3 cultural health model, multiple domain model, and the conceptual framework of HIV/AIDS communication developed for the Borana pastoralist community (see Chapter 4).HIV responses in the context of Borana pastoralists need to be tailored to the specific socio-cultural context of the local community (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa 2007a). The dominant idea of the Afro centric cultural health model and HIV/AIDS communication conceptual framework for Borana

is that western-oriented health theories and models of behaviour change do not provide an adequate contextual approach to HIV/AIDS prevention in the developing countries such as Ethiopia.

As a result, focusing on the contexts like culture, gender, religion/spirituality, and communication dynamics of the target community is important to address health messages. The study by Mtenga et al (2016) confirms that communication about HIV prevention interventions, including condom use, couples counselling, and testing is problematic among married couples in sub-Saharan Africa due to aspects related to marital norms, gender power relations, and relationship quality. There is a need to integrate gender into the design interventions of HIV/AIDS prevention in Africa so that the prevention and communication strategies are effective for both genders (Belus et al 2022). Reforming the socio-cultural systems of the pastoralist community is essential. The current systems increase gender inequalities and are the source of all day-to-day problems (for example: equal opportunities for education, income, cultural practices, and devaluation of women) (Klaas, Thupayagale-Tshweneagae & Makua 2018; Kar et al 2013). Accordingly, the FGI participants (female household_Guto kebele and female household_Haro Dimtu kebele) said that:

> *Women are engaged in indoor activities. Men (husbands) have more access to HIV/AIDS information. Women (wives) are economically dependent on men (husbands). Pastoralist women (wives) have less access to the media. Unlike the urban community, the rural women in the pastoralist community have less access to health information* (Female household_Guto kebele).

> *Marriage in the community is culturally arranged by the family. Who to marry is not only based on the interest of the women but also the interests of the family and clans. Men have more chances to decide whom to marry* (Female household_Haro Dimtu kebele).

The FGI data (like the in-depth interview data in Chapter 6) indicated that women and girls in the pastoralist community of Borana are still vulnerable to HIV/AIDS due to gender inequality. This is consistent with the report by UNAIDS (2019) which confirmed that gender inequality in the developing countries has been exposing women to the risks of HIV/AIDS. Health information in sub-Saharan Africa is more accessible to men than women (Chory et al 2023; Achen, Atekyereza & Rwabukwali 2021; Masquelier & Reniers 2018; Mtenga et al 2018).

This is because of the gender-based discrimination that provides men with more access to public information concerning HIV/AIDS than women. For instance, in the rural areas, men have more opportunities to listen to locally accessible radio programmes compared to women. The data further indicated that health campaigns rarely occur in the remotest pastoralist community. This implies that there are HIV/AIDS information, education, and communication disparities between the urban and the rural community, which mainly affect the underprivileged pastoralist women (wives) in the rural areas. This is consistent with the UNAIDS report (2019) which stated that gaps in HIV/AIDS information, education, and communication are among the factors why women and girls remain vulnerable to HIV. Gender equality has positive implications on the access of contextualised and gender inclusive HIV/AIDS information, education, and communication for social behavioural change to occur.

7.5.1 Women's economic empowerment for effective HIV/AIDS communication in the Borana pastoralist community

Economic opportunities have been associated with risky sexual practices, such as exchanging sex for money, drugs, housing, food, and safety (Fentie et al 2023; Teshale& Tesema 2023). Ultimately, these practices can place women at risk of contracting HIV (Riley et al 2007:182). Transactional sex (sex for money) is common in sub-Saharan Africa. Economic dependency forces women to engage in sex work, which is defined as the provision of sexual services in exchange for money, goods, or other benefits (Vandepitte et al 2006). A lack of socio-economic resources is linked to the practice of riskier health behaviours, which can lead to the contraction of HIV. Empowering female pastoralists (women) economically, regardless of gender differences, would allow them to decide on their sexual rights. Economic empowerment of women pastoralists would discourage risky sexual practices, such as exchanging sex for money (Teshale & Tesema 2023). Accordingly, the focus group interview participants (female household_Renjikebele, female household_Haro Dimtu kebele, and female household_Guto kebele) pointed out that:

> *Women are less empowered to make decisions on their sexual rights. They hardly decide on the financial resources. Girls' education, although improving these days, has been the neglected part that forces women into early marriage. Most women (girls) move to towns in search of paid work* (Female household_Renji kebele).

Economic challenges expose women to commercial sex work. Women lack information about health issues when compared to men. Women are more silenced by the culture (Female household_Haro Dimtu kebele).

HIV/AIDS campaigns usually occur in the towns. Condom promotion is limited to the urban corridors. Women are less exposed to condom promotion (Female household_Guto kebele).

Like the in-depth interview data (Chapter 6, section 6.8), the above responses indicated that female pastoralists were less empowered to make decisions on their resources, including the sexual rights of women due to the long-standing gender discrimination and wrong attitudes toward the rights of women, including sexual and economic rights. It is evident from the data that the sexual rights of pastoralist women (wives) are in the hands of men (husbands). This is primarily because of the deep-rooted socio-cultural and economic dependence of women. The data is consistent with the argument that women and girls in developing countries within sub-Saharan Africa are still vulnerable to HIV/AIDS due to gender inequality (UNAIDS 2019).

Gender discrimination and violence due to a lack of education are among the factors that expose women and girls to HIV (UNAIDS 2019). This is echoed in the study by Ramjee and Daniels (2013) which reported that low economic status has been associated with earlier sexual experience, lower condom use, having multiple sexual partners, increased chances that the first sexual encounter is non-consensual, and a greater likelihood of having had transactional sex or physically forced sex. Dworkin et al (2009) confirms that the relationship between traditional gender roles and risk shows how men are socialised to initiate and expect sex, whereas women are socialised to be responsive to men's request and to focus on their partner's wants and needs. Traditional gender roles and expectations in sub-Saharan Africa deny the economic power of women. As a result, women are forced to obey decisions made by men or the cultural community (Fentie et al 2023; Chetty-Makkan et al 2021; Mtenga et al 2018). Biological, social, behavioural, cultural, economic, and structural factors expose sub-Saharan African women to the problem of HIV/AIDS (Ramjee & Daniels 2013). In the context of this study, gender empowerment as well as economic power among the Borana pastoralists is important to address the HIV/AIDS epidemic. It builds women's confidence to protect themselves from unsafe sexual practices brought on by economic dependence. Gender empowerment also encourages women to test for HIV and to know their HIV status, as well as preventing new infections of their partners.

Borana female pastoralists should be empowered to prevent HIV/AIDS. The communication approach among Borana pastoralists should promote gender equality so that men (husbands) and women (wives) can be equally committed to prevent the spread of HIV/AIDS, regardless of their gender differences (Kapadia-Kundu et al 2022; Achen, Atekyereza & Rwbukwali 2021; Sileoet al 2018).

The data also asserted that women in the pastoralist community have no equal rights to decide on economic resources (Kaba 2019; Kaba, Ame & Mariam 2013; Kaba 2011). Most pastoralist women have no marriage right outside of the cultural circle. The economic dependency of women, as well as the cultural imposition of marriage exposes women to different problems including sexual exploitation. Women in the pastoralist community cannot fully exercise their right to education. This is compatible with the study by Ramjee and Daniels (2013) which identifies that many structural vulnerabilities place African women at risk, including gender inequality and gender-based violence, migration, and health seeking stigma. According to the study by Ramjee and Daniels (2013), hierarchical gender roles such as male sexual entitlement, low social value, the lack of female power, and ideas of manhood linked to the control of women, result in lower levels of education among women. The lack of public roles or economic power for women, the lack of family, social, and legal support, all expose women to the risks of HIV/AIDS. The study by UNDP (2016:3) confirms that African women have been subjected to a wide array of discriminatory practices, violence, and disregard of their human rights for diverse reasons, ranging from culture and tradition to war and economic factors. Women face severe deprivations in their health due to factors such as early age marriage, sexual and physical violence, and economic dependence. Women in Africa, and more specifically Ethiopia, are victims of significant human rights abuse, including sexual discrimination, sexual abuse, intimate violence, political marginalisation, and economic deprivation (UNDP 2016). Like the findings in Chapter 6, section6.5, the participants confirmed that there has been gender discrimination and women's economic dependence among the Borana pastoralists that negatively affect their sexual rights. This could expose them to the danger of HIV/AIDS risks and implies that socio-cultural and economic factors contributed to HIV/AIDS risks among the pastoralist women in Borana. The problem of HIV/AIDS can be addressed with due attention to the contextual factors in the community. This study contributes toward a socio-cultural path of HIV/AIDS communication for Borana pastoralists, which indicates that HIV/AIDS communication should consider the socio-cultural context of the pastoralist population. Tailoring HIV/AIDS communication into the contextual factors of the local area is essential for effective social behavioural change.

7.6 RELIGIOUS /SPIRITUAL CONTEXTS TO COMMUNICATE HIV/AIDS

This theme is based on the PEN-3 cultural health model, and culturally oriented conceptual framework of HIV/AIDS communication that recommends the integration of cultural, religious/spiritual, gender, and community-based communication contexts for effective message delivery and social behavioural change concerning HIV/AIDS. Understanding religious/spiritual issues have become important to address health services including HIV/AIDS.

7.6.1 Religious/spiritual pathways to HIV/AIDS communication

Religious groups interpret the HIV/AIDS epidemic considering their beliefs and teachings. These interpretations have often led to public assertions on HIV/AIDS education, prevention and care, as well as to the shaping of public attitudes toward those afflicted by (or at risk of) HIV/AIDS infection (Agadjanian 2020; Gichuru et al 2018; Mapingure et al 2021; Munyaradzi et al 2016; Shaw & El-Bassel 2014; Zou et al 2009). HIV/AIDS is a chronic disease. Its healthcare should go beyond clinical complaints and health professionals need to include religious/spiritual issues to tackle the risks of HIV/AIDS (De Oliveira Valente, da Silva & Cavalcanti 2022). However, the clinical-biomedical model still prevails in many developing countries where religion/spirituality is still not properly incorporated into the practice, despite substantial academic references on the matter (De Oliveira Valente, da Silva & Cavalcanti 2022). In addition, there have been different religious views and practices that either support or negate the effort to reduce the spread of HIV/AIDS in developing countries of Africa, such as Ethiopia. In sub-Saharan Africa, religious beliefs concerning sexuality have led to a fracture in the relationship between religious institutions and public health efforts (Agadjanian 2020; Gichuru et al 2018; Mapingure, Mukandavire & Chingombe 2021; Munyaradzi et al 2016; Shaw& El-Bassel 2014; Idler 2014). The views of many religious traditions discourage and/or undermine behaviours associated with the risk of sexual health issues and HIV/AIDS. This religious view, which negates the risks of HIV/AIDS, may encourage the spread of the epidemic (Idler 2014). Religious views and practices concerning HIV/AIDS pose challenges to HIV/AIDS communication and education about sexual health in religious communities and may serve as barriers to HIV treatment and care (Medved 2017). Religious coping and spiritual well-being, as well as social support could serve as facilitators to HIV/AIDS prevention, treatment, and care (Medved 2017).

Therefore, there is a need to consider religious/spiritual issues in communication on HIV/AIDS. Positive religious resources and/or teachings should be used to tackle the spread of HIV/AIDS while religious views and practices that exacerbate the spread of the epidemic need to be challenged.

This study considers the cultural health model and culturally driven conceptual framework of HIV/AIDS communication. The cultural framework of HIV/AIDS communication incorporates religion/spirituality as one of the essential domains to address HIV/AIDS messages properly. The cultural framework of communication states that spirituality/religion serves an important role in coping, survival, and maintaining overall well-being within African cultures and communities (Arrey et al 2016:14). In sub-Saharan Africa, people strongly believe in the power of God in their HIV/AIDS treatment and well-being. Spiritual/religious resources including prayer, meditation, church services, religious activities, and believing in the power of God is believed to help individuals cope with HIV/AIDS (Arrey et al 2016). However, the religious/spiritual beliefs and practices also need to help societal well-being in terms of disease prevention and control. Religion has undeniably been a very potent motivator of behaviour and behavioural change throughout history — it may logically play an important role in determining patterns of HIV/AIDS (Sovran 2013:3-4). HIV/AIDS prevention in the Borana pastoralist community requires the involvement of faith-based organisations such as churches and mosques. Religious/spiritual teachings should help to avoid polygamy and extramarital sexual relations that contribute to the spread of HIV/AIDS in sub-Saharan Africa (Sovran2013). This is also prevalent in the Borana pastoralist community where there are religious/spiritual practices that hamper health communication. The in-depth interview data (Chapter 6, section 6.7) and the data from the FGIs affirmed that some religious doctrines encourage polygamy and extramarital sexual intercourse which undermined the problem of HIV/AIDS. Faith-based institutions do not have similar world views on how to combat HIV/AIDS due to doctrine differences. In addition, religious teachings and church regulations (for example faith healing), negatively shape healthcare-seeking behaviour (Mapingure, Mukandavire & Chingombe 2021:8; Munyaradzi et al 2016). The idea of faith healing posits that HIV/AIDS can be cured through the spiritual activities like holy water, the Holy Spirit, and prayers. These spiritual practices discourage message receptions of HIV/AIDS information, education, and communication. The effectiveness of faith healing using scientific inquiry is controversial, while there is no — or limited — evidence of the therapeutic effectiveness of faith healing modalities such as prayer (Peprah 2018).

Nevertheless, it is evident that a significant number of patients in sub-Saharan Africa resort to faith healing as a first choice and believes in its potency.

Faith practices and beliefs can provide a sense of peace and hope. It can help people to prepare for (and accept) death (Genrich & Braithwaite 2005). People often turn to religion to make sense of and come to terms with being HIV-infected. Prayer, meditation, faith in God, and other forms of religious participation have frequently been cited by PLWHA in Tanzania and other African countries as major strategies for coping with HIV/AIDS (Makoae et al 2008). Religious beliefs about HIV can also contribute to fatalistic attitudes and passive resignation, which hinders participation in treatment (Hess & McKinney 2007). The belief that prayer can cure HIV may also challenge adherence to antiretroviral (ARV) treatment programmes (Hess & McKinney 2007). Faith healing has the potential to influence HIV/AIDS communication message reception. Religious doctrines and cultural norms are forces that bear profound influence on human health, which is confirmed by Mariam (2018). Religious communication should address a moral code that contains the duties and responsibilities of all people to ban the danger of HIV/AIDS (Rieffer 2006). FGI data (like the in-depth interview data in Chapter 6) reveals that religious/spiritual beliefs and practices had its own advantages and disadvantages in tackling HIV/AIDS. There are positive religious teachings that the healthcare workers should consider while communicating about HIV/AIDS. However, the religious teachings and practices that expose people to the risks of HIV/AIDS should be tackled systematically in collaboration with the faith-based institutions/religious leaders. The FGI data (like the in-depth interview data in Chapter 6) confirmed that HIV/AIDS teachings in the Borana pastoralist community were not properly integrated with the religious/spiritual contexts. Accordingly, the focus group participants (male household_Haro Dimtu kebele, female household_Guto kebele, male household_Mata Gafarsa kebele and female household_Mata Gafarsa kebele) pointed out that:

> *Some religious people consider HIV/AIDS as divine punishment for man's sin. Some religious institutions oppose polygamy. Some religious institutions advocate polygamy* (Male household_Haro Dimtu kebele).

> *Waaqaa (Oromo Indigenous religion) protects us. Waaqaa did not limit the number of children we need to have. We can marry several wives as far as we can manage* (Female household_Guto kebele).

Some people believe that the Holy Spirit can cure HIV/AIDS. There are people who give their testimony via religious media channels that they are cured from HIV/AIDS (Male household_Mata Gafarsa kebele).

HIV/AIDS is simple for God. It is all about praying and approaching God with a good heart. God's miracles are in various places. It is observed while the Holy Spirit cures HIV/AIDS and cancer. What is impossible for health professionals is possible for God (Female household_Mata Gafarsa kebele).

HIV/AIDS messages are not well integrated with religious contexts from the onset of material preparation. Prophets may not believe in the epidemiological aspects of the disease. Positive religious teachings are not well practised. It needs coordinated efforts (Male household_Haro Dimtu kebele).

It is evident from the data that religious/spiritual views and practices influence HIV/AIDS prevention. Religion/spirituality offers people away to understand suffering and illness. Spiritual beliefs can also affect how people cope with illness. By addressing spiritual issues of patients, loved ones, and ourselves, we can create a more holistic and compassionate systems of care. In the Borana pastoralist community, there is the dominant religious belief that HIV/AIDS is sent from God (as discussed in Chapter 6). This is consistent with the study done by Balogun (2010) which reported that many religious people in Africa regarded the emergence of HIV and AIDS as divine punishment for man's sins because of people's sexual promiscuity. This is also underlined in the Borana pastoralist community where there have been perceptions and beliefs that HIV/AIDS can be cured through religious/spiritual means. In the Borana pastoralist community, especially protestant religious followers accepted that the Holy Spirit could cure one from HIV/AIDS and other chronic diseases such as cancer. A study by Zena (2010) reported:

"Many individuals are trying to cope with HIV/AIDS in a spiritual way, which may be related to the fact that there is no medical cure for HIV yet. This is true of Christians as well as some Muslims among people living with HIV/AIDS, leaving behind their homes in various localities. To this effect, they are leaving their homes and moving to these sites where they can obtain spiritual care."

The use of faith healing and other Indigenous health resources for HIV/AIDS treatment is widespread in sub-Saharan African countries (Bodeker & Burford 2007: 16-22).

This is also true for the Borana pastoralist community. The participants, especially Orthodox religious followers, believed that holy water could cure any disease, including HIV/AIDS (Roura et al 2010). The study by Mapingure, Mukandavire & Chingombhe (2021) and Munyaradzi et al (2016) reported that religious teachings and church regulations, for example faith healing, negatively shape healthcare-seeking behaviour in Africa. The FGI data, like the in-depth interview data (Chapter 6), asserted that Borana pastoralists use different spiritual means like holy water and prayer to cure illness. There were religious people who had confidence in divine power, other than medical health information. The positive religious/spiritual resources were not effectively used to discourage practices that hamper HIV/AIDS message receptions.

Currently, there is no medicinal cure for HIV/AIDS (Delgadillo et al 2022). However, the Borana pastoralist community believe that faith healing can cure HIV/AIDS. There are religious people who believe that God is omnipotent and can save human beings from any sort of illness, including HIV/AIDS. This is one of the obstacles in addressing HIV/AIDS messages. Such religious/spiritual beliefs in the society would negatively affect HIV/AIDS message reception (Song & Qin 2019). The influence of religious organisations is widely recognised as a key factor in the fight against the HIV epidemic, particularly in sub-Saharan Africa (Dilger et al 2010). Social attitudes have increasingly continued to threaten global HIV/AIDS prevention effectiveness (Sayles et al 2009). However, faith-based programmes have been long regarded as influential social approaches to form positive responses to HIV/AIDS (Blevins, Jalloh & Robinson 2019). Recent scholars argue that religion underpins prejudice while assisting (Anderson et al 2008; Blevins 2015).

Religious leaders, cultural leaders, together with the health workers, have the power to discourage practices such as extramarital sexual relations, early marriage, FGM, and widow inheritance that exacerbates the spread of HIV/AIDS among the Borana pastoralist community. This is consistent with the study by Zou et al (2009) which reported that on the community level, religious organisations are influential social networks that have the power to support or stigmatise people living with HIV/AIDS, promote or impede HIV/AIDS education, and endorse or reject the treatment of HIV. Religious norms and values such as faithfulness in marriage, compassion, and purity play key roles in reducing HIV/AIDS risks (Shaw & El-Bassel 2014).

HIV/AIDS communication approaches should consider the cultural, as well as religious, influence among the pastoralist community.

There is a need to have contextualised, pastoralist-friendly communication and intervention approaches to bring a shift in the misguided religious/spiritual beliefs and practices, as these cripple the campaigns against HIV/AIDS among the Borana pastoralists. Positive religious values and norms should be integrated with HIV/AIDS communication to bring about the intended behavioural change.

In the Borana pastoralist community, religious teachings should aid to avoid polygamy, extramarital sexual relations, and the misperception about faith healing that contributes to the spread of HIV/AIDS (Sovran 2013). Community healthcare providers should deliver contextualised, accurate, and updated information about the modes of HIV/AIDS transmission, counselling, and guidelines for safe practices. To limit the impact that negative spiritual beliefs and practices have on the spread of HIV/AIDS, psycho-educational interventions should target the pastoralist community in religious settings (Olaore & Olaore 2014). The faith-based institutions together with health caregivers should work towards clearing the spiritual/religious misperceptions and ill practices regarding HIV/AIDS. In the context of the Borana pastoralist community, religious leaders, cultural leaders, and health workers should work together to inform, educate, and communicate the cultural and religious/spiritual practices that contribute to the spread of HIV/AIDS in the community. In addition, there is a need to capitalise on the positive cultural and/or religious resources, rather than focusing on blaming harmful cultural and/or religious practices, to tackle the spread of HIV/AIDS through contextualised communication.

7.7 HIV/AIDS COMMUNICATION APPROACHES FOR EFFECTIVE MESSAGE DELIVERY

This theme focused on tailoring HIV/AIDS messages to a user-friendly communication approach that suits the socio-cultural contexts of the pastoral community. An appropriate and user-friendly communication approach is deemed essential to address HIV/AIDS messages among the Borana pastoralists. When designing HIV/AIDS communication for the Borana pastoralist community, it is important to consider the overall communication contexts and the strategies to be used for effective message delivery. It is also necessary to understand the target population so that content, channels, and styles of communication are relevant to the target population of the pastoralist community. In addition, using multiple communication strategies that consider the specific contexts like natural features, culture, language, religion/spirituality, gender, and literacy levels of the pastoralist community would help to ensure effective HIV/AIDS communication.

7.7.1 Appropriateness of the HIV/AIDS communication approach: moving away from a general approach to targeted communication

In the past, prevention was the main goal of HIV/AIDS communication interventions using mass media (Agegnehu et al 2020; Touriño et al 2018; Rice & Atkin 2012; Muturi 2005).AIDS programmes worldwide mainly depended on mass media campaigns to disseminate the information about the epidemic(Agegnehuet al 2020; Touriño et al 2018).However, communication scholars have become unsure about the effectiveness of the top-down mass media communication to change behaviour (Chandler et al 2022; Dutta-Bergman 2005a). As a result, alternative communication strategies that consider the contexts of the target community are crucial. This is because providing people with knowledge about a disease using mass media may have little or no impact on their behaviour. User-friendly communication approaches that help to provide information about the consequences of the behaviour, about groups that support behavioural performance, and about ways to overcome barriers to behavioural performance is crucial (Muturi 2005). A combination of dialogic communication, spiritual practices, and other forms of religious and cultural communication is important in addressing HIV/AIDS messages. Interpersonal communication plays a vital role in information dissemination and influencing attitudes, beliefs, and behaviours. This approach to communication identifies information giving and sharing processes, interpersonal sensitivity, and partnership building that is core communication skills to predict better outcomes (Ashley 2006). The approach also includes community empowerment and participation in addressing issues that affect society (Muturi 2005). HIV/AIDS is an issue that requires moving beyond dissemination of information to include interpersonal dialogues on risk factors, and prevention strategies with the participation of socio-cultural institutions whose influences are critical in changing the societal norms, cultural beliefs, attitudes, behaviours, and practices that contribute to the widespread epidemic. HIV/AIDS messages, medium of communication, and approach of the messaging should suit the different societal contexts (Aghaei et al 2023; Vermund, Van Lith & Holtgrave 2014:2; Bekalu, Eggermont & Viswanath 2017), because audiences differ in their assumptions, attitudes, self-efficacy, and receptivity to messages. Targeted communication is about ensuring that the message reaches the target audiences (Thorton 2009). Targeting communication must begin with tailoring the message to the context of the target audiences. Health communicators need to customise messaging to meet the needs and values of the specific target audiences. The communication should understand the characteristics unique to the target community.

Tailoring health communication helps to enhance the relevance of the information presented and to produce greater desired changes in response to the communications. Tailoring HIV/AIDS communication to the context of Borana pastoralist community, however, does not mean encouraging harmful cultural and/or religious practices that hamper effective HIV/AIDS communication and message reception. The communication approaches need to tackle the deep-rooted harmful practices like FGM, *Jaala-Jaaltoo* sexual networks, widow inheritance (see in-depth interview data, Chapter 6) that fuel the spread of HIV/AIDS. HIV/AIDS communication strategies such as IEC, social marketing, media use, official meetings and local campaigns did not effectively consider the use of Indigenous socio-cultural and religious resources.

HIV/AIDS communication in the developing countries seemed focusing on the general population (Khandu, Tobgay & McFarland 2021). The communication and message delivery approach need to be tailored specifically for key populations instead of the current generalised approach (Khandu, Tobgay & McFarland 2020). Institution-based programmes include interventions in the workplace, in schools, and in health facilities. Targeted group communication within the institutional settings may not address the interests of the clients with different socio-economic, cultural and health behaviours. In sub-Saharan Africa there are gaps among health organisations in developing enhanced, targeted information, education, and communication materials and promotional events to address misinformation, myths, and the lack of understanding of HIV prevention and care (Mapingure, Mukandavire & Chingombe 2021). The institutional-based generalised HIV/AIDS communication cannot address the interests of the widely dispersed pastoralist community. The participants from both male and female households note that:

> *HIV/AIDS communication is top-down. The communication approaches did not consider the mobile pastoralist situation. Health workers use similar communication methods both for urban and rural areas (highlanders and lowlanders)* (Male household_Haro Dimtu kebele).

> *HIV/AIDS communication is mostly formal and persuasive. Social networks and cultural associations in the community are not well utilised. The way messages are designed overlooked the pastoralist context. There is no affirmative action concerning addressing HIV/AIDS issues among the disadvantaged pastoralist population* (Male household_Renjikebele).

There is no pastoralist-specific HIV/AIDS communication approaches and supports (Female household_Guto kebele).

The communication approach does not break the public taboo about condom use. Cultural expectation about sexual secrecy remains a challenge to publicly communicate about and promote condoms (Female household_Haro Dimtu kebele).

The feedback from the FGIs indicated that the HIV/AIDS communication approach among the pastoralist community followed the general approach. This approach of disease prevention that focuses on the general population cannot effectively address HIV/AIDS issues among the specific cultural community's that have unique features that need special consideration. The generalist approach of HIV/AIDS communication overlooked the specific characteristics of the Borana pastoralist community that needs targeted communication. Targeted messaging, that is created and tailored to the specific contexts of Borana pastoralists who share similar behaviour and lifestyles, are crucial to address HIV/AIDS information, education, and communication. In the Borana pastoralist community, HIV/AIDS communication did not consider the specific nature of the mobile drought-stricken and marginalised pastoralist community that need affirmative action for effective HIV/AIDS prevention. This is consistent with the study by Khandu, Tobgay & McFarland (2021) which reported that HIV responses should be tailored specifically for key populations instead of the generalised approach.

7.7.2 Healthcare workers approach to HIV/AIDS communication: health message acceptance and cultural inclusion

Sustainable and comprehensive responses to HIV/AIDS depend on multilevel programmes that address community level inequalities such as gender (as noted in section 7.5), along with considering social stratifies such as ethnicity, age, location, socio-economic status, as well as larger socio-cultural structures that shape society's perception (Viswasam, Schwartz & Baral 2020). Understanding the underlying intersecting factors that contribute to the spread of HIV/AIDS in diverse communities is critical for addressing differential HIV/AIDS risks, outcomes, and barriers as explained and noted in the findings in sections 7.4, 7.5, 7.6, and7.7. Integrated responses that lead to people-centred HIV/AIDS prevention, looking for common elements and determinants to move closer to common causes and solutions, is essential to communicate HIV/AIDS (Johnson et al 2019). HIV/AIDS communication should include understanding the socio-cultural and religious resources that would help to address

HIV/AIDS messages. It is important to understand that harmful practices in the community cripple the effort to combat the spread of HIV/AIDS. HIV/AIDS communication in the Borana pastoralist community needs to consider the local views and practices that either speed up or slow down the spread of HIV/AIDS in the community. Understanding what motivates people's behaviour, knowing how to address these motivations appropriately, and taking into consideration people's culture when developing programmes addressing HIV/AIDS are essential to change behaviours and attitudes towards the epidemic. For example, understanding community level contexts, like the socio-cultural environment in which HIV/AIDS communication and prevention education takes place, is important to address HIV/AIDS. Furthermore, HIV/AIDS communication requires understanding the approaches of communication that enable people's participation, which can help to ensure that HIV/AIDS prevention and care is embedded in local cultural contexts. Health communication is a valuable tool in the prevention and treatment of HIV/AIDS, as it is for many other aspects of public health (Wakefield et al 2010). HIV/AIDS communication among the Borana pastoralists should help the target community bring the social behavioural change by considering the contexts outside of the individual such as socio-cultural, religious/spiritual, gender, environment, and climate contexts (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa 2007a; Zimmerman, Christakis & Meltzoff 2007).

Systematic and strategic approaches of thinking about the role communication can play in addressing HIV/AIDS messages among a cultural society like the Borana pastoralists are crucial(Mapingure, Mukandavire& Chingombe 2021 Rogers et al 2021).Health communication interventions are more likely to succeed when they use multiple coordinated communication elements to reach people with consistent high-quality messages through a variety of appropriate channels, considering cultural contests, and in a variety of forms (Douglas et al 2014). HIV/AIDS communication among the Borana pastoralists succeed when it considers the contexts in the community and uses the appropriate communication approaches that suit the reality of the local targeted pastoralist community. Contextualised HIV/AIDS messages and user-friendly ways of message delivery play a crucial role to bring the intended social behavioural change among the pastoralist community in Borana, Ethiopia (Mapingure, Mukandavire & Chingombe 2021). Communication can strengthen social networks and reflect social norms that support healthy behaviour, and it can help change norms that encourage unhealthy behaviours (Douglas et al 2014). Communication helps providers explain services and treatments to patients and motivate them to use those services consistently and effectively (Douglas et al 2014).

The focus group data revealed that HIV/AIDS communication approaches in the Borana pastoralist community did not consider the informal communications, such as family level conversations and the already established social networks of *Busaa-Gonofaa* (Indigenous associations for social secularity). Accordingly, the data indicated that healthcare workers under Borana pastoralists used formal means of communication approaches such as meetings to address HIV/AIDS messages. The FGI participants noted that:

> *Health workers use mostly formal means to persuasively communicate. Meetings and official forums are typically used to communicate about the epidemic. Local means of communication such as social networking and cultural associations in the community are not well utilised to communicate about HIV/AIDS* (Male Household_Renji kebele).

> *Health workers usually focus on giving HIV/AIDS information. The communication is more professional. Health workers try to persuade the community to accept HIV/AIDS messages. Local resources such as community rituals, social networks, and cultural institutions are not well integrated into HIV/AIDS messages* (Male Household_Guto kebele).

The FGI data revealed that healthcare workers among the Borana pastoralists focused on giving HIV/AIDS information — the epidemiological aspects of the disease based on scientific explanation. The content of HIV/AIDS (the knowledge domain) was focused on more while undermining the socio-cultural aspects that influence the communication and message reception. HIV/AIDS communication among the Borana pastoralists focused more on giving out warning information than helping the community to internalise health messages and change their practices. The communication was more focused on cautioning the community to ban their unsafe sexual practices. It overemphasised the problems of unsafe sexual practices that fuel the spread of HIV/AIDS while de-emphasising the problems of risky cultural and/or religious views and practices that expose the community to HIV/AIDS.

HIV/AIDS communication between a parent and child in sub-Saharan Africa tends to be authoritarian and unidirectional, characterised by vague warnings rather than direct, open discussion (Mtenga et al 2016). Conveying HIV/AIDS messages through community participation was not well addressed. The epidemiological aspects of HIV/AIDS were considered, while the cultural contexts and the communication approaches familiar to the pastoralist community were overlooked.

HIV/AIDS communication needs to consider the reality of the pastoralist community through a participatory approach that considers the contexts of the target community. It should not be a one-way communication approach where one is trying to persuade the target community to accept the intended messages. The FGI participants (male household_Guto kebele, male household_Mata Gafarsa kebele, and male household_Haro Dimtu kebele) noted that:

> *The intention of the health workers is to persuade the community to accept HIV/AIDS messages. There is no pastoralist-specific approach to HIV/AIDS communication* (Male household_Guto kebele).

> *Health workers give more focus to the content. The receivers' situations are not considered* (Male household_Mata Gafarsa kebele).

> *HIV/AIDS communication is dominated by experts (healthcare workers). The communication is top-down. It is not supported by the Borana oral traditions such as cultural drama, songs, dance, and fables to engage the community* (Male household_Haro Dimtu kebele).

The data asserted that HIV/AIDS communication was more top-down and the cultural contexts of the community was overlooked. The communication focused more on the persuasive approach of message reception without considering the contextual factors at the bottom. Decisions to persuade people rather than enable them to make an informed decision may affect message reception (Oxman et al 2022).In HIV/AIDS communication the target community should be supported to make informed decisions about their own health, rather than focusing on persuading them to accept the health messages. The FGI data confirms that the communication focused more on the HIV/AIDS message transmission, and not on creating meaning and practices from the specific contexts of the pastoral community. The message acceptance and decoding on the receiver's side was not well considered.

HIV/AIDS communication focused on expert-oriented information dissimilation that intends to persuade the individuals in the community. It did not focus on the collectivist culture to promote collective behavioural change. Assuming that individuals are rational thinkers and one can bring positive behavioural change based on western behavioural models, is not enough in the context of Borana. The cultural approaches to social behavioural change that consider contexts in the community are crucial (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome &Airhihenbuwa 2014; Airhihenbuwa 2007a; Zimmerman, Christakis &

Meltzoff 2007). It is crucial to recognise that individual health is situated within a context of intrapersonal relationships, cultural practices, as well as economic and social conditions (Storey et al 2014).

Similarly, participatory HIV/AIDS communication would help to recognise the health literacy of the target pastoralist community in Borana, which relates to their capacity to interpret HIV/AIDS information. This includes approaches that emphasise their capacity to interpret health information, create meaning, and support critical thinking and empowerment (Sørensen et al 2012). A cultural approach to HIV/AIDS communication allows prevention and care methods to come from within the culture, maintain socio-cultural ownership, and credibility (Uwah 2013). This is consistent with the study by (Nguyen et al 2012) which states that HIV/AIDS control programmes for marginalised communities in resource-constrained settings (like the rural contexts of the developing countries of Africa), should use a participatory, community-based communication approach that considers the contexts of the target community. Healthcare workers need to understand and apply the essence of socio-cultural, religious, and gender inclusion for effective HIV/AIDS prevention among a culturally bound community like the Borana pastoralists.

7.7.3 Community-oriented participatory approach to HIV/AIDS communication

HIV/AIDS communication initiatives have evolved to favour the participatory approach above one-directional transmission of information to the public (Burger 2015). This is consisted with the study by (Tomaselli 2011:8–17) which reported that a participatory communication approach rests on the assumption that an HIV/AIDS communication initiative stands the best chance of resulting in behaviour change if members of the target community participate in the communication initiative. Techniques of the participatory approach are incorporated in the workings of HIV/AIDS communication as mechanisms to involve the target audiences in the message production process, as it is found that this is more likely to persuade them to adopt new behaviour (Burger 2015).The dominant communication approach that uses directive communication methods to promote expert-defined changes in individual's health-related knowledge and practices is not effective to address HIV/AIDS messages in a collectivist community such as the collectivist culture of Borana. This is because the individual's health behaviour is influenced by different actors like peers, family, and community. In addition, individual's health decisions in a collectivist culture such as Borana is also influenced by factors like culture, religion, gender and the economy.

The culture of engaging the target community in HIV/AIDS prevention is crucial (Chandler et al 2022; Burns et al 2020; Cornish et al 2014). Participatory approaches that genuinely consider where people live and work is important to address health issues (Burger 2015; Creative Exchange 2008).

HIV/AIDS communication in the Borana pastoralists 'community should consider the pastoralist environment. The communication and prevention approaches need to consider the local opportunities through a participatory fashion. Health communication is more fruitful if it is integrated with the norms, values, and wisdom of the local community (Kaba 2013; Taylor 2007). HIV/AIDS communication among the Borana pastoralists failed to utilise the local resources. This is comparable to the study by Kaba (2013) which reported that HIV prevention interventions in Borana are lagging with a top-down approach, loosely coordinated, and poorly exploring which local resources and opportunities are available to improve the success and pace of interventions. The participants (female household_Haro Dimtu kebele, female household_Mata Gafarsa kebele and female household_Renji kebele) reflected that:

> *Cultural leaders promote polygamy. The health workers did not communicate the problems of HIV/AIDS risks related to polygamy very well. The cultural leaders are publicly advocating polygamy* (Female household_Haro Dimtu kebele).

> *Borana is guided more by the customary laws. Borana has its own Indigenous religion (Waaqaa), cultural dress, cultural dance, cultural songs, and rituals. HIV/AIDS communication overlooked these domains* (Female household_Mata Gafarsa kebele).

> *Community participation in HIV/AIDS communication is less. The health extension workers in the rural areas focus on expert communication. The communication is to persuade people to accept HIV/AIDS messages. HIV/AIDS education is not using the social networks such as Buusaa-Gonofaa. Healthcare workers rarely come to the rural areas during drought seasons* (Female household_Renji kebele).

Rules and regulations dictating the way a Borana should live are renewed and adapted at each *GumiiGaayyoo* cultural assembly. *GumiiGaayyoo* assembly is among the cultural opportunities to prevent the spread of HIV/AIDS. The above data indicated that HIV/AIDS communication in Borana did however not use the Indigenous cultural resources and

institutions to address HIV/AIDS messages. Nowadays, Borana cultural leaders, through the *GumiiGaayyoo* cultural assembly, give the direction that a Borana man have more than one wife. Such decisions by the cultural leaders would encourage polygamy without due care to HIV/AIDS. The data in Chapter 6, section 6.4.5.1 indicated that polygamy is culturally approved among the pastoralist community.

The decision of polygamy would expose the community to HIV/AIDS risks. This is consistent with the study by Gazimbi et al (2020) which reported that men and women in sub-Saharan Africa who are in polygamous relationships are more likely to engage in extramarital sex which exposes them to the risks of HIV/AIDS. The decision that encourages polygamy implies that there is a coordination gap between health institutions and the cultural leaders. The HIV/AIDS communication and prevention approach among the pastoralist community depends more on the expert-oriented communication. The communication favoured the content of HIV/AIDS communication more, rather than the cultural norms, values, and the pastoralists' way of life. There is a need to consider Borana cultural opportunities to communicate HIV/AIDS messages. Polygamy, as a form of marriage, allows a person to have more than one spouse. In sub-Saharan Africa it typically takes the form of polygyny, which involves men marrying multiple wives (Reniers & Watkins 2010). The widespread practice of polygyny is one feature of many sub-Saharan African contexts that may be relevant to understanding patterns of HIV prevalence. Although there have been contradicting studies whether polygyny is a means for elevating HIV transmission in sub-Saharan African countries, the recent study by Gazimbi et al (2020) reported that people who are in polygamous relationships are more likely to engage in extramarital sex. The findings further indicated that polygyny amplifies risky sexual behaviours such as sexual networking and concurrent sexual partnerships, all of which are found to be significantly associated with the risk of HIV transmission (Gazimbi et al 2020). It was noted in section 7.7.3 as well as Chapter 6, section 6.4.5.1 that polygamous marriage in Borana has cultural recognition so that men have the right to marry more than one woman based on his resources. Traditionally, widows and divorced women can benefit from polygyny, as they are more likely to be married in polygamous than monogamous unions. This, without the culture of testing for HIV/AIDS, creates concurrent sexual networks within marriages between multiple wives and their husband (Mah & Halperin 2010). The decision to engage in polygamous sexual relations in the Borana pastoralist community through the *Gumii Gaayyoo* decree is to encourage a greater number of children that would help to preserve the land resources of Borana in the future. This is consistent with the study by (Gazimbi et al 2020) which reported that in sub-Saharan Africa polygamy is one way to increase the

number of children per household and ensures child replacement in the context of high infant mortality. Secondly, polygyny increases the possibility of wealth accumulation for the husband because of free labour supplied by several wives and children (Gazimbi et al 2020).

The data revealed that HIV/AIDS communication among Borana pastoralists did not engage the community to bring about social behavioural change. This means the target community was not participating in the HIV/AIDS campaigns. The local resources such as cultural and religious institutions were not adequately utilised to ban practices that expose the community to the risks associated by HIV/AIDS. Moreover, the local people had no equal and fair opportunity to participate in their community affairs including HIV/AIDS prevention. The participants (female household_Renji kebele and female household_Guto kebele) reflected that:

> *The community has no significant participation in the HIV/AIDS prevention. The communication is more expert-oriented and the coordination between health workers and cultural and religious leaders is less. Harmful cultural practices that hamper HIV/AIDS prevention are not well sorted-out (*Female household_Renji kebele).
>
> *The pastoralists are not equally engaged in HIV/AIDS issues. There is no equal opportunity. HIV/AIDS communication is less planned and contextualised (*Female household_Guto kebele).

It is evident from the data that HIV/AIDS communication among the Borana pastoralists community was top-down and less participatory. This is in contrast with the study which reported that community engagement in health issue is about creating the space for people to reflect on their situation, and finding pathways of change, which work in contexts (Burgess et al 2023; Dzimiri, Dzimiri & Batisai 2019). It implies community engagement in health issues are not about the spread of messages or putting in place processes of consensus-based decision-making, which may often be quite “unrepresentative” and subtly coercive (Nguyen et al 2012). Knowledge and understanding of the community’s predominant attitudes, perceptions, and practices will help ensure more effective and respectful communications and interactions, leading to culturally responsive engagement activities. In the Borana pastoralist community, it is essential to reiterate the importance of context in health communication, which should address the collective culture. People need to be part of driving their own change within the contextual domains. Finding ways to work with culture, may hold the key to a more responsive development that avoid pre-determined solutions,

and recognise the need for distributed creativity and initiative in sustainably addressing development challenges such as health (Burger 2015; Creative Exchange 2008).

In the context of the Borana pastoralist community, an engagement is about creating the space for people to reflect on their situation and the risks of HIV/AIDS. An engagement is also about finding pathways of change which work in context, rather than the promulgation of messages, or putting in place processes of consensus-based decision-making, which may often be quite "unrepresentative" and subtly coercive (Hofstede, Hofstede & Minkov 2010). Culture is not only about using the native language of the community. There is the misconception that language represents the entire cultural issue which, is broad and complex. Language is one aspect of culture. The HIV/AIDS communication approach needs to consider other socio-cultural domains of the target community to effectively address the intended message and bring about the social behavioural change. In the Borana pastoralist community, HIV/AIDS communication should be embedded into the local resources such as familiar languages of the local community. In addition, there should be participatory HIV/AIDS communication with fair participation of the local community through the notion of cultural engagements. This would address contextualised HIV/AIDS information, education, and communication via the bottom-up approach of participatory disease prevention. This is consistent with the study by Campbell et al (2013) which reported that community involvement is at the core of the concept of HIV/AIDS prevention. In addition, Campbell et al (2012) stated that an HIV/AIDS-competent community is one where community members work collaboratively to support each another in achieving sexual behaviour change, the reduction of stigma, co-operation with volunteers and organisations seeking to provide HIV-prevention and AIDS-care, and effectively accessing the existing health services.

7.7.4 Collectivist cultural approach to HIV/AIDS communication: the core to behavioural change patterns

Cultural engagement plays a vital role in determining the level of health of the individual, the family, and the community (Chandler et al 2022; Burns et al 2020; Cornish et al 2014). This is particularly relevant in the context of Africa, where the values of extended family and community significantly influence the behaviour of the individual (Omodara, Gibson & Bowpitt 2022). The behaviour of the individual in relation to family and community is one major cultural factor that has implications for sexual behaviour and HIV/AIDS prevention and control efforts (Omodara, Gibson & Bowpitt 2022). African culture posits that a person's individual identity is intertwined with his or her kinship's identity, with lineage, and its

solidarity constituting an important context of “Africanity”. In Africa, people remain attached to their traditional cultural roots (Kuada & Hinson 2012). Collectivist cultures emphasise the needs and goals of the group over the needs and desires of the individual. In such cultures, relationships with other members of the group and the interconnectedness between people play a significant role in each person’s identity. Collectivism contrasts with individualism, in which personal needs take precedence. In the context of HIV/AIDS prevention in Africa, the collectivist cultural values of extended family and community significantly influence the behaviour of the individual (Airhihenbuwa& Webster 2004). Thus, a culture-centred approach to HIV/AIDS prevention, care, and support is increasingly recognised as a critical strategy (Airhihenbuwa 2007a). A PEN-3 cultural model for Africa also gives emphasis to the culture of the target African community in HIV/AIDS prevention, care, and support (Airhihenbuwa & Webster 2004).

In the Borana pastoralist community, where collective cultural values influence the day-to-day lives of the community, HIV/AIDS communication needs to focus on the broader cultural contexts to bring sustainable change regarding HIV/AIDS. African cultures are collectivistic in nature (Airhihenbuwa 2007a; Airhihenbuwa& Webster 2004). In collectivistic cultures, individuals are embedded within their group identity, and the notion of a separate, autonomous self is de-emphasised (Akkuş, Postmes & Stroebe 2017). Individuals who ascribe to collectivistic values also tend to engage in social comparisons to ensure they are conforming to group norms. In sub-Saharan Africa, social and cultural norms demarcate the boundaries surrounding sexuality communication (Bastien, Kajula & Muhwezi 2011). In a collectivist culture in sub-Saharan Africa, individuals are highly influenced by the larger community regarding health behaviour. This can be applied to the Borana pastoralist community as they were standing out in a way that reflects poorly on the group, leading to intense feelings of shame (Akkuş, Postmes & Stroebe 2017). Similarly, HIV/AIDS communication in Borana should consider the collective cultural norms and values concerning sex and sex-related affairs to prevent the spread of HIV/AIDS. HIV/AIDS prevention should use the positive cultural resources to prevent HIV/AIDS while tackling views and practices that hamper HIV/AIDS prevention in the pastoralist community. HIV/AIDS communication skills in the collectivist cultural community of sub-Saharan Africa are low, which negatively affect the communication at family, community, and society levels (Bastien, Kajula & Muhwezi 2011). In the collectivist cultural community of Borana, individual-oriented HIV/AIDS communication does not guarantee a change in the community’s behaviour concerning HIV/AIDS. This is because individual behaviour is influenced by the collective cultural norms, values, views, and practices.

Socio-behavioural factors are strong drivers of HIV in collectivist cultural groups such as Borana, but the interactions between these social factors (such as social support, cultural aspects, education, neighbourhood characteristics, the way their influence shifts over time and space and influences HIV prevalence and incidence), are poorly understood (Thiabaud et al 2020). HIV/AIDS communication in developing countries within Africa does not consider the social issues. The participants explained that:

> *Individually oriented HIV/AIDS communication is dominant. Social behavioural change is less emphasised. There is a culture of resistance to condom use. The communication approach does not break the public taboo about condom use. Silence about sexual issues remains a challenge to publicly communicate and promote condom use. Inclusive HIV/AIDS communication is lacking. HIV/AIDS communication did not consider social structure in the pastoralist community. HIV/AIDS teaching focuses more to the individual level understanding and behaviour* (Female household_Haro Dimtu kebele).

> *HIV/AIDS education focuses more on the individual's behavioural change. The education is usually given in certain sites such as clinics. The community is far from the district, not fairly accessing HIV/AIDS education. However, families and community influence individuals. HIV/AIDS communication is less focused on the collectivist culture of Borana* (Female household_Guto kebele).

The above feedback from the participants indicated that HIV/AIDS communication among the Borana pastoralist focuses more on individual behavioural change. This approach of communication did not consider that individuals are under group pressure in a collectivist society such as the Borana pastoralists. The conceptual framework developed for this study gave insight that HIV/AIDS communication in Borana should follow the socio-cultural path for effective social behavioural change to occur. For instance, condom promotion under the Borana pastoralists should consider the collectivist culture of the community. The context of condom promotion is more acceptable and can grasp audiences' attention if it is presented in the cultural contexts of the target community. An urban style of condom promotion may not be effective for the pastoralist community whose situations are culturally bound. Contextual factors, such as cultures of collectivism versus individualism, shape HIV-coping strategies (Adia et al 2019). Collectivism is a tendency, on the individual and societal level, to view oneself as interdependent and a member of a group, rather than as an independent being.

In collectivist cultures, people feel as if they belong to larger in-groups or collectives, which care for them in exchange for loyalty (Hofstede & Bond 1984). In individualist cultures, people are frank and to the point when it comes to communication, no matter how hurtful the message; whereas in a collective culture, hurting someone's feelings is reprehensible (Watson 2014). In collectivist societies, people in families or groups are protected in exchange for loyalty. As a result, collectivist cultures value collaboration, communalism, constructive interdependence, and conformity to roles and norms.

A collectivist culture is likely to emphasise the importance of social harmony, respectfulness, and group needs over individual needs. Socio-cultural factors such as social networks, cultural norms, beliefs, religion/spirituality, and gender expectations determine the health behaviour of a cultural society, such as Borana. Given the role that cultural norms play in society, it is reasonable to expect that various cultural attributes can influence the outcomes of a pandemic. As such, outcomes are dependent on social compliance to broad and varied behavioural strategies (Erman & Medeiros 2021). Collectivism influences the individual and community's capacity to engage health promotion practices (Kawabata 2013).

HIV/AIDS communication in Borana should consider and recognise the influence of culture on the community's health behaviour (Wondmeneh & Wondmeneh 2023; Achen, Atekyereza & Rwabukwali 2021; Both, Etsub & Moyer 2013). The communication approach and message design should give focus to the collective culture, which can influence the social behavioural change (Kawabata 2013). Collective cultural attributes that accelerate the spread of HIV/AIDS among the Borana pastoralists need to be tackled through designing and contextualising culturally specific HIV/AIDS communication. Positive cultural attributes that encourage open HIV/AIDS communication and prevention mechanisms should be promoted. The impact of HIV/AIDS communication strategies to promote a family and community's well-being is severely limited due to the importance of cultural context and health practitioners' limited attention to the culturally grounded worldview of some communities (Kagawa-Singer et al 2015). Transforming health, including HIV/AIDS, programmes in the Borana pastoralist community requires considering the cultural relevance of the communication approaches. This is consistent with the study by Airhihenbuwa et al (2009) which reported that framing HIV/AIDS communication messaging to engage the target communities, help to address culturally appropriate HIV/AIDS education, information, and communication. The PEN-3 cultural model focuses on the cultural logic of decision making about the HIV/AIDS pandemic. In the context of this model, the societal reasoning and rationale are at the foundation of health messages, focussing on the populations and

communities that are the intended audience (Airhihenbuwa et al 2009). In addressing HIV/AIDS messages among the Borana pastoralist community, the importance of the positive cultural aspects of the community and people, their collective spirit, and their cultural logic must not be overshadowed in communication about the epidemic (Airhihenbuwa et al 2009).HIV/AIDS communication among the Borana pastoralists must respond not only to individuals but also to the community as a collective. Individuals must not be privileged over the collective or community. The HIV/AIDS behavioural change models and theories such as the health belief model, social learning theory, trans-theoretical model, and social marketing theory need to be adapted to the African collectivist culture. Social cohesion fostered by aspects such as religiosity, cultural ethos, and a community-based approach play a key role in unifying people towards fighting HIV and AIDS in the collectivist culture of Borana (Dzimiri, Dzimiri & Batisai 2019).

7.8 CONCLUSION

This chapter gave insight into the deep-rooted misperceptions concerning HIV/AIDS, which emanated from the cultural, religious/spiritual, and gender views among the Borana pastoralist community. HIV/AIDS is considered a punishment from God because of people's sin; protection from the disease is only through God's power and the power of prayer. Most pastoralists in sub-Saharan Africa doubt the existence of HIV and are therefore not responsive to HIV/AIDS interventions (Both, Etsub & Moyer 2013). HIV/AIDS is perceived as an urban disease. Its spread was attributed to the urban community and the more mobile pastoralist population group, the men (husbands). The socio-cultural factors such as the *Jaala-Jaaltoo* sexual networks, polygamy, extramarital sexual relations, widow inheritance, female genital mutilation, early marriage, drug use, and traditional livestock markets were among the realities hampering HIV/AIDS prevention efforts in the pastoralist community. Additionally, the taboo topic of sex in the Borana pastoralists held back condom promotion as well as an open dialogue concerning HIV/ADS. The findings are consistent with the study by Tenkorang et al (2011) which reported that personal and cultural beliefs, as well as cultural practices and traditions, could strongly influence health behaviours including sexual relationships, sexual health, and associated risk reduction strategies such as condom use. The FGI data gave important insight into the religious/spiritual factors such as faith healing and the use of holy water that negatively influenced HIV/AIDS communication and message receptions. Gender inequality among the Borana pastoralists affected the access to HIV/AIDS information, education, and communication. HIV/AIDS communication approaches at the study site were influenced by the western behavioural change models and theories.

The communication was generalist, top-down, persuasive, expert-oriented, and individual-behavioural-change oriented which overlooked the collectivist culture of Borana. The communication approaches did not integrate the Indigenous social networks (*Marroo, Buusaa Gonofaa*) and socio-cultural, economic, and political institutions such as *Gadaa* and *Gumii Gaayyoo*. The health programmes in the pastoral community in general did not consider the specific culture of pastoralism. There is a need to tailor HIV/AIDS communication to the cultural, religious/spiritual, gender, and unique characteristics of the Borana pastoralist community for effective social behavioural change to occur. Chapter 8 presents data on the HIV/AIDS policy document analysis pertaining to this study.

CHAPTER 8

PART III: FINDINGS AND ANALYSIS OF THE HIV/AIDS POLICY OF ETHIOPIA

8.1 INTRODUCTION

In this chapter the discussions and analysis of the national HIV/AIDS policy document of the Federal Democratic Republic of Ethiopia was presented in relation to the socio-cultural approach to HIV/AIDS communication. The policy document was analysed in terms of the cultural health model of HIV/AIDS communication (Chapter 3, Part II) and the culturally oriented conceptual framework of HIV/AIDS communication for Borana pastoralists (Chapter 4).The document analysis, while supplementing the in-depth and focus group interviews data, was used to assess how much the national HIV/AIDS policy of Ethiopia addressed the socio-cultural domains to communicate contextualised HIV/AIDS messages for the citizens. According to the research objectives, socio-cultural contexts, religious/spiritual contexts, gender, and communication approaches were the focus areas for the document analysis. To analyse the document, major themes and sub-themes were developed. This chapter addressed the following research questions:

1. *Does the HIV/AIDS policy of Ethiopia address the socio-cultural contexts of the pastoralist communities, like the Borana in Ethiopia?*
2. *What is considered acceptable and culturally appropriate HIV/AIDS communication approaches for the Borana pastoralist community?*

8.2 BACKGROUND OF NATIONAL HIV/AIDS POLICY OF ETHIOPIA

The national HIV/AIDS policy is the guiding principles that set the tone and outline the actions required to address contextual domains like the culture of the target community. The policy can describe a course of action to be adopted and pursued by a government or organisation (WHO 2013). The policy is important in designing and establishing programmes as it provides a constant reference point before, during, and after a programme is implemented. Nationals need to develop viable medical and programmatic guidance on the provision of HIV/AIDS services (WHO2013). However, the adoption of such recommendations within national HIV/AIDS care and treatment policies is influenced by contextual factors operating within economic, political, and social spheres (Edwards & Barker 2014).

Studies by researchers such as Nelson et al (2020) and Church et al (2015) have shown that the HIV/AIDS policy needs to consider the contexts of the target community.

To contextualise the situation when it comes to policy evolvement, the Ethiopian national HIV/AIDS policy evolved from non-existent before 1984, to a strategic plan to intensify a multi-sectoral HIV/AIDS response that is still in practice (Mohamed 2019). The Ethiopia national HIV/AIDS policy adoption has been through different stages and processes. The policy formulation was mainly based on the nature of the stakeholder's involvement, the spread of the HIV/AIDS epidemic, and the nature of the political system (HAPCO 2004). Mohamed (2019) affirms that there were three defined phases of HIV/AIDS policymaking periods from 1984 to 2005 in Ethiopia. The period from 1984 to 1987 was considered a period of preparedness for HIV/AIDS policy making. The second phase of the government response to AIDS was from 1987 to 1992. This period is considered a remarkable period for the government's HIV/AIDS policy evolution as it took on a more human-centred approach. However, this phase of policy formulation did not involve most public stakeholders in the broader policy environment (Mohamed 2019). The third stage from 1992 to 2007 was to address the overall objective of providing an enabling environment for the prevention and mitigation of the HIV/AIDS epidemic.

Document analysis was a suitable tool to understand and evaluate the HIV/AIDS policy of Ethiopia in terms of the cultural contexts (Bowen 2009). The policy document was analysed and interpreted to elicit meaning, gain understanding, and develop practical knowledge on the Ethiopian national HIV/AIDS policy in terms of addressing the local domains like culture, religion/spirituality, gender, and language (Corbin & Strauss 2008). In analysing the HIV/AIDS policy of Ethiopia, the same cultural approach to the HIV/AIDS communication framework that guides this study was used to frame the document analysis. The document analysis was used to supplement data collected through other means such as interviews and focus group discussions (Yin 2009). The document analysis was vital to substantiate the primary data collected through in-depth and focus group interviews (Yin 2009). The rationale behind the document analysis was to validate the incorporation of contextual domains such as culture, gender, religion/spirituality, and user-friendly HIV/AIDS communication in the HIV/AIDS policy document of the Federal Democratic Republic of Ethiopia.

8.3 PROCEDURES FOLLOWED TO ANALYSE THE HIV/AIDS POLICY OF ETHIOPIA

The HIV/AIDS policy document analysis involved skimming (superficial examination), scanning (thorough examination), and interpretation of the content of the document in terms of the guiding frameworks of the cultural approach to HIV/AIDS communication. This process combined elements of content analysis based on themes (Yin 2009). The content analysis was organised into categories related to basic research questions. In undertaking the document analysis, relevant contents of the HIV/AIDS policy document related to the objectives of the study were identified (Corbin & Strauss 2008).

Thematic analysis was used as a form of pattern recognition within the data, with emerging themes becoming the categories for analysis (Braun & Clarke 2006). The process involved a careful, more focused, e-reading and review of the data. The researcher took a closer look at the selected data and performed coding and category construction based on the data's characteristics to uncover themes pertinent to the phenomenon explored in this study. Based on the research objectives, predefined codes were used in this document analysis. The use of predefined code was crucial and relevant because the document analysis was supplementary to other research methods employed in the study (Braun & Clarke 2006). To analyse the HIV/AIDS policy document, guiding questions were developed to lead the document analysis in line with the research objectives. The researcher demonstrated objectivity (seeking to represent the research material fairly) and sensitivity (responding to even subtle cues to meaning) in the selection and analysis of the data from the documents.

The document analysis considered basic policy issues such as policy content, policy text, and policy consequences. These aspects of the policy helped the researcher to focus on framing the document analysis. Bell and Stevenson (2015) states that the policy context is about the forces and values that have driven a policy to come into being. This relates to the socio-political environment and requires understanding of the antecedents of the policy: the issues and pressures that gave rise to a need for the policy in the first place. This helped the researcher to understand how the HIV/AIDS policy of Ethiopia related to local contexts (Bell & Stevenson 2015).

The policy text was subjected to detailed data analysis (Silverman 2006). The researcher used content analysis to find out why the HIV/AIDS document was structured or framed in a certain way. Questions about the purposes and the values that underpin the policy were discussed in the context of the research objectives. The researcher was able to draw inferences that may link to theories about the policy arena and consider both, what was covered and what was not covered in the policy text. The policy content was mainly

interpreted from the socio-cultural domains (Silverman 2006). Policy consequences are related to the way in which a policy is implemented. Policy implementation practice can affect the way the users of the policy interpret it (Ryan 1995). The policy document was analysed to consider the effectiveness of procedures documented to give consistent guidance to the implementation of the policy in terms of the socio-cultural contexts (Ng 2016). The general structure of the document was analysed in line with the research objectives (Rhonda 2013).

8.4 THE FORMULATION OF THE HIV/AIDS POLICY OF ETHIOPIA

This theme addresses the main HIV/AIDS policy issues of Ethiopia such as the policy document production, accessibility, policy initiative, language, target audience, position of policy makers, and inclusiveness of the policy document in relation to the cultural contexts in Ethiopia.

8.4.1 Contextual gaps in developing an HIV/AIDS policy of Ethiopia

The document analysis stated that Ethiopia developed the national HIV/AIDS policy in 1998 with the help of foreign donor organisations and policy advisors (MoH 1999). Accordingly, this study affirms that the Ethiopian HIV/AIDS policy was adopted from the western HIV/AIDS policy initiative and interests. The HIV/AIDS policy formulation of Ethiopia was influenced by the international funding organisations and foreign interests. As the report of PEPFAR (2018a) and Global Fund (2018) stated, the success of Ethiopia's HIV response has largely been driven by external funding from development partners, particularly the US. The study by Sama and Nguyen (2008) further stated that African health systems are intractable because of powerful international donors that causes fragmented health efforts while undermining local systems. Furthermore, the study by O'Reilly et al (2017) reported that developing countries primarily relied on international donors' support and interests in developing their policies including health (O'Reilly et al 2017). Lack of strong citizen participation in development policy affects creating a viable society, sustainable growth, and equitable distribution of benefits. The HIV/AIDS policy formulation as well as implementation of Ethiopia depended on the donor originations. In this regard, article 10, sub-article 3 states that:

> *MOH shall prepare countrywide HIV/AIDS prevention and control programmes taking into account the resource implication on which grounds the government shall allocate budgetary subsidy. The government shall facilitate the sources mobilisation from international and donor community to respond to the challenges of the epidemic* (MoH 1999:34).

The interest of donors (western organisations) such as the United Nations (UN), United States Agency for International Development (USAID), the World Bank, and the World Health Organisation (WHO) shaped the formulation as well as the implementation of the Ethiopian health policy in general, and the HIV/AIDS policy. This influenced the use of home-grown contexts such as the inclusion of socio-cultural contexts to prevent and control the spread of HIV/AIDS. In terms of campaign strategies, the western-originated health models and theories focus on individualistic behavioural change and epidemiological aspects of disease prevention (Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa 2007a). The western behavioural models and theories of disease prevention overlooked the contexts of the developing countries in Africa (Obregon 2000:5).The western policy influence of health systems in Africa largely surpass what is accessible through the public system to encompass a patchwork of providers, whether these are biomedical entrepreneurs, churches, NGOs, or traditional healers (Sama & Nguyen 2008).The HIV/AIDS policy need to consider the notion of the PEN-3 cultural health model (Chapter 3,Part II) which states that HIV/AIDS prevention in Africa should be tailored to the socio-cultural contexts of the specific community (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa 2007a). In addition, the multiple domain model, discussed in Chapter 3, Part II, explained that HIV/AIDS prevention is influenced by contextual factors outside of the individuals. The national HIV/AIDS policy should address the socio-cultural, gender, religious/spiritual, demographic, environmental, and contextual variables in the specific population group (Zimmerman, Christakis & Meltzoff 2007). However, being unable to focus on the Indigenous socio-cultural resources in formulating the HIV/AIDS policy, created strategic gaps which would result in poorly contextualised HIV/AIDS prevention, control, and care across the different segments of the population such as the Borana pastoralists(Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome &Airhihenbuwa 2014; Airhihenbuwa 2007a). The document analysis asserted that that Ethiopian Ministry of Health (MoH) took almost five years to develop the HIV/AIDS strategy. The strategy focused on close examination among high-risk groups, prevention activities (IEC, behaviour change communication, and condom distribution), care and support.

The MoH was the key implementer, working with regional partners. However, the document analysis indicated that the HIV/AIDS policy was limited in scale and unmatched to the size of the problem of HIV/AIDS in the country of Ethiopia. For instance, the HIV/AIDS policy analysis asserted that the issue of the pastoralist context was not a major concern of the policy formulation and discussions at national level. Studies related to HIV/AIDS in sub-Saharan Africa focused on the urban areas (Van et al 2012). This document analysis indicated that the Ethiopian HIV/AIDS policy was by large based on urban studies and contexts, which overlooked the pastoralist contexts in the rural areas (Badruet al 2023; Maulide et al 2021; WHO 2018). The spread of HIV/AIDS among the pastoralist community was not adequately identified or incorporated into the national policy contexts. The study by Rogers et al (2021) stated that development approaches among the pastoralist community in sub-Saharan Africa overlooked the importance of the local community's context in planning and setting a development agenda. Overlooking pastoralist contexts in the development policy would affect addressing contextualised HIV/AIDS messages among the pastoralist community in sub-Saharan Africa. Being unable to address the pastoralist contexts in the national HIV/AIDS policy formulation, hampered the process of tailoring the HIV/AIDS communication to the local domains of the pastoralist community, such as the Borana Oromo. Additionally, the conceptual framework developed for this study revealed that HIV/AIDS prevention in Borana should follow the socio-cultural path for effective social behavioural change to occur. HIV/AIDS programmes and communication approaches in Borana should not be exported from the western culture (Dzimiri, Dzimiri & Batisai 2019). The prevention programmes and policy strategies need to suit the specific culture of the rural Borana pastoralists. Furthermore, the HIV/AIDS policy landscape should consider the social cohesion fostered by aspects such as social networks, religiosity, cultural ethos, and a community-based approach that play a key role in unifying people towards fighting HIV/AIDS in a collectivist cultural community like that of the Borana pastoralists (Dzimiri, Dzimiri & Batisai 2019).

8.4.2 Problems in accessing the HIV/AIDS policy of Ethiopia by local audiences

The document analysis and the researcher's overall observation revealed that the HIV/AIDS policy document of Ethiopia wasn't accessible to the local community. Until recently, the policy material was only in hardcopy, since there was lack of internet access in the country. Today, the policy document is accessible online, although few segments of the population (urban) were able to access the digital policy document. The rural areas such as the Borana pastoralist community had no access to the policy materials.

The researcher could not find the hardcopy of the national HIV/AIDS policy document at district offices in the study area. As indicated in the in-depth interviews (Chapter 6) the healthcare workers at the study site did not have an HIV/AIDS policy document in their offices. As a result, the researcher travelled approximately 120km to the Federal HIV/AIDS Coordination Office in Addis Ababa to access the official HIV/AIDS policy document for the content analysis from the socio-cultural perspective of HIV/AIDS communication. By not making the national HIV/AIDS policy accessible, the local community would struggle to understand to policy contexts, content, objectives, purpose, important factors, and implementation strategies. This would create misunderstanding regarding policy direction during the implementation phases. The HIV/AIDS policy document should be accessible to the local stakeholders so that there would be a clear understanding on the policy issues. Thus, there is a need to make the policy document accessible in the respective languages of the local community so that the concerned bodies, such as healthcare workers at the bottom, could understand the policy context properly.

8.4.3 Choice of language and its effect on the HIV/AIDS policy of Ethiopia

Organisational language practice and policy are not neutral but reflect social and political power relations in a country (Keshet et al 2019). The micro-level of working groups and the local people is subject to the influential power relations at the macro-level (Keshet et al 2019). Language plays a guiding role in the maintenance or alteration of the community's social fabric (Dugassa 2006:4). That national policy should properly address the language interest of the target people for its effectiveness. However, the document analysis asserted that the HIV/AIDS policy material of Ethiopia was primarily in English and Amharic (MoH 1999).It was prepared in the English language to get the attention and support from the international donor organisations. In addition, the policy was formulated with the help of international consulting bodies whose working language is English. In the context of Ethiopia, the rural community cannot read and write in English. Amharic, although it is a working language of the Federal Democratic Republic of Ethiopia, is not effectively used by most of the rural communities in Ethiopia, like the Borana pastoralists whose native language is Afan Oromo (Oromo language).

The national HIV/AIDS policy should have been translated into the native languages of the local community for effective policy communication and understanding. Many lower- and middle-income countries have high levels of linguistic diversity, meaning that health information and care is not available in the languages spoken by most of the population,

which would create a problem for understanding health information due to literacy challenges (Mgbako, Conard & Mellins 2022; Tasah 2021; Lindgren et al 2018).The recognition of language needs in formal planning and reporting in the context of HIV/AIDS-related healthcare, is extremely low (Bachelor et al 2019). Health policy should address the context of language for proper implementation (Keshet et al 2019). Afan Oromo, the native language of most of the Ethiopian population in Oromo, is not the federal working language in the country. As a result, the national HIV/AIDS policy formulation in Ethiopia is not in Afan Oromo, which has its own negative influence on the effectiveness of health information and policy implementation at the bottom. Limiting national HIV/AIDS policy formulation to two languages (English and Amharic), when there are more than 80 languages in Ethiopia, would affect the accessibility and communication clarity of the policy document for the local audiences. It was also indicated during the in-depth interviews that the HIV/AIDS education materials in Ethiopia were translated from Amharic language, which lacked the cultural and linguistic flavours of the non-Amharic speaking community such as the Borana pastoralists. As explained in Chapter 2, little attention has been given to the development of the pastoralist community in Ethiopia (Tofu et al 2023). Pastoralists are a neglected group who lack access to basic services like health education (Lumborg et al 2021). As a result, illiteracy is quite high as most children are out of school (UNICEF 2014). In Africa, including Ethiopia, the policymakers often overlook development activities in the pastoral areas, focusing on the interests of agriculture and urban dwellers (Mohamed2019).

There is a strong relationship between health, culture, and language. Language and culture provide the practical context for comprehension of health information (Andrulis &Brach 2007:4). The culturally bound beliefs, values, and preferences a person holds influence how they interpret healthcare messages. Addressing audiences' language and culture is vital for knowing how health literate the person is in each situation. Accordingly, the national HIV/AIDS policy document of Ethiopia needs to consider the language diversities at the bottom for effective communication. The language consideration in the national policy development including HIV/AIDS, serves to eliminate the alienation of the messages, makes the message culturally appropriate, geographically and educationally more understandable and acceptable (Ahmad 2012). The Borana pastoralist community could however not access contextualised HIV/AIDS policy document in their own native language, Afan Oromo. The healthcare workers in the local areas of the pastoralist community also had no access to the national HIV/AIDS policy document in their native language (Afan Oromo) for effective communication and message delivery. This would hamper effective HIV/AIDS communication programmes.

In addition, inability to use the language of the target Borana pastoralist community would have not only health implications, but also political meaning. The national HIV/AIDS policy development of Ethiopia should consider the language of the society at the bottom, as languages provide meaning, relations, interrelations, and foster self-reflection of the past, and critical thought into the learning process (Dugassa 2006:4). The HIV/AIDS policy of Ethiopia should address the language interest of the target community by translating the policy materials for effective communication and understanding the policy level contexts.

8.4.4 Problems of tailoring the HIV/AIDS policy to the context in rural Ethiopia

The national HIV/AIDS policy document of Ethiopia indicates that the overall objective is to prevent and control HIV/AIDS. The policy document analysis however, gave insight that the policy formulation approach gave more focus to the population who had access to information, education, and communication (the urban population).The national HIV/AIDS policy generally focused more on the macro contexts, such as the economic, political, and organisational issues in the policy formulation and implementation. The following is a list of the national HIV/AIDS general policy focus areas of Ethiopia (MoH 1999:25):

1. Reinforcing the implementation of effective measures to prevent and control the spread of HIV/AIDS.
2. Make the necessary provision of care and support to people living with HIV/AIDS and their affected family members.
3. Strengthen the collaborative efforts with regional and international organisations for the prevention and control of HIV/AIDS.
4. Ensure the protection of the human rights of people living with HIV/AIDS.
5. Provide healthcare to people living with HIV/AIDS on a scheme of payment according to ability, with special assistance for those who cannot afford to pay.
6. Promote research and studies on HIV/AIDS and make use of the outcome for preventative, curative, and rehabilitative purposes.
7. Develop the capacity to detect the HIV infection and its spread in the community through teaching and a disease surveillance system.
8. Promote integrated coordination of the government, NGOs, and the private sector for the prevention and control of HIV/AIDS.

The general policy focus areas affirm that the role of local resources and institutions was overlooked in the policy formulation to curb the spread of HIV/AIDS.

For instance, the roles of different bodies such as opinion leaders, elders, religious people, and cultural institutions were not clearly stated. As indicated in the in-depth interviews, the FGIs, and the document analysis, the national policy document of Ethiopia did not use the Indigenous resources in the pastoralist community such as their knowledge and institutions in the national HIV/AIDS policy development. This is compatible with the study by Serbessa et al (2016) which reported that HIV/AIDS intervention programmes in the pastoralist regions of East Africa were not well integrated into to the needs of those impoverished pastoralist populations. The rural community in the harsh ecological zones such as the Borana pastoralists were overlooked in the national HIV/AIDS policy formulation. This is compatible with the study by the WHO (2018) which reported that insufficient attention is given to the marginalised and poor regions in Africa regarding the formulation of a health policy. There is over-reliance on urban professionals and politicians as intermediaries between rural communities and development actors regarding health communication in Africa (Rogers et al 2021). Inability to consider the pastoralists in the policy landscape would affect the consideration given to the marginalised environmentally disadvantaged communities in Ethiopia, such as the Borana. The document analysis further indicated that HIV/AIDS policy audiences of Ethiopia focus on the general population. Specific and target populations such as the pastoralists were less represented in the policy. Development policy interventions in Africa have long failed to accommodate the needs and preferences of pastoralists (Rogers et al 2021).

The study by Serbessa et al (2016) reported that IGAD countries (Intergovernmental Authority on Development) should collaborate in designing and implementing more effective prevention and control programmes of HIV/AIDS among the pastoralist community. Pastoralist people in sub-Saharan Africa were politically and economically marginalised in state policy, including health policy (Pavanello 2009). Disregarding the pastoralist community in the national development policy makes participatory processes difficult (Herrera, Davies & Baena 2014:4). The HIV/AIDS programmes need to be more focused geographically and directed to the regions, districts, and/or communities that exhibit higher prevalence rates (World Bank Global HIV/AIDS Programme 2008). The HIV/AIDS policy should consider the contextual factors operating within economic, political, and social spheres of the respective countries (Edwards & Barker 2014).

8.4.5 The position of policy makers to contextualise the HIV/AIDS policy of Ethiopia

The document analysis indicated that the policy makers' position seemed to reflect the position of the then government and the western donors and advisors (Ethiopia HIV/AIDS Policy 1999). The document was beautified by the western languages and scientific jargon. However, the Indigenous health beliefs and knowledge of the community at the bottom was not given due attention. The policy was adopted from the western health policy (MoH 1999). The document did not focus on the incorporation of local issues based on the home-based research findings for policy formulation. The Indigenous contexts (such as culture) were not properly addressed to formulate the HIV/AIDS policy of Ethiopia. The position of the policy makers leaned towards a western approach to HIV/AIDS prevention, control, and care, which did not consider the collectivist culture of the Ethiopian population. The policy formulation should consider Afro centric HIV/AIDS prevention approaches that is bottom-up, user-friendly, participatory, and context specific as explained in Chapter 6 and 7. The HIV/AIDS communication in the collectivist culture of Africa should consider the socio-cultural contexts of the specific community (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa 2007a). In addition, the multiple domain models discussed in Chapter 3, Part II explained that HIV/AIDS prevention is influenced by contextual factors outside of the individuals and as such, should address the socio-cultural, gender, religious/spiritual, demographic, environmental and contextual variables in the specific population group (Zimmerman, Christakis & Meltzoff 2007).

In short, the position of the policy makers was not different from the then government position (Mohamed 2019). This is because the HIV/AIDS policy was influenced by the then EPRDF government (Ethiopian People's Revolutionary Democratic Front), who was highly dependent on the western donors for policy formulation and implementation. HIV/AIDS formulation in Ethiopia was not determined by the interest of home professionals, but based on the political interest of the government, which was linked to donor organisation. HIV/AIDS policy makers need to consider the contextual factors operating within economic, political, and social spheres of the respective countries (Edwards & Barker 2014). The policy makers need to consider the real context of the local community for proper integration of the policy messages with the life experiences on the ground. The national HIV/AIDS policy, as well as the policy makers, needs to consider the contextual factors such as the geographically harsh environments of the marginalised pastoral community for effective, user-friendly HIV/AIDS intervention (Rogers et al 2021; Herrera, Davies & Baena 2014)

8.4.6 HIV/AIDS policy perspectives of Indigenous resources in the community

The analysis of the HIV/AIDS policy of Ethiopia, like the in-depth interviews (Chapter 6, section 6.4) and FGIs (Chapter 7, section 7.4.1), revealed that the policy materials mainly focused on the institutional matters such as politics, economy, and health, overlooking the socio-cultural contexts in the local community. The policy formulation did not give attention to factors such as culture, religion, environments, demography, climate, and related contexts in the local areas of a marginalised population, like the Borana pastoralists, for effective HIV/AIDS prevention. This is consistent with the study by Rogers et al (2021) which reported that the health policy of Africa relied on a simplistic approach that overlooked the complexity of overlapping (and often contested) issues in the cultural community. The policy gave more focus to the issues of medical epidemiology in HIV/AIDS prevention and treatment. The role of cultural domains was not well addressed in the document. The in-depth interviews as well as the FGIs indicated that the Indigenous resources in the pastoralist community were not adequately integrated into the HIV/AIDS communication (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome & Airhihenbuwa2014; Airhihenbuwa 2007a).

The practices on the ground concerning HIV/AIDS prevention, in one way of another, have policy implication (Rogers et al 2021).This means the national HIV/AIDS policy should pay attention to the contextual domains in the local areas (Iwelunmor, Newsome &Airhihenbuwa 2014; Airhihenbuwa 2007a). Pastoralists have often been marginalised (politically and economically) in state policy (Pavanello 2009), which makes development participatory processes difficult (Herrera, Davis & Baena 2014). Approaches to development should emphasise the importance of community participation in the planning and setting of the development agenda (Rogers et al 2021). The policy document preparation favours the urban and literate population. This is consistent with the study by Rogers et al (2021) which reported that in sub-Saharan Africa there is over-reliance of urban professionals and politicians as intermediaries between rural communities and development actors regarding development communication such as HIV/AIDS. Development interventions have long failed to accommodate the needs and preferences of pastoralists in Africa (Rogers et al 2021). HIV/AIDS programmes and communication approaches in Borana should not be exported from the urban culture (Dzimiri, Dzimiri & Batisai 2019). The HIV/AIDS policy materials in Ethiopia should consider the rural realities and contexts such as cultural norms, values, belief systems, religion/spirituality, gender, as well as socio-demographic and environmental factors that play a key role in unifying people towards fighting HIV and AIDS in collectivist cultural community, like the Borana pastoralists (Dzimiri, Dzimiri & Batisai 2019).

8.4.7 Problems related to the lifespan of the HIV/AIDS policy of Ethiopia

The National HIV/AIDS policy of Ethiopia was developed 24 years ago (MoH 1999).The government of Ethiopia has formulated strategies and guidelines to eradicate the spread of HIV/AIDS by 2030. Therefore, the HIV/AIDS policy of Ethiopia is still under implementation with its inadequate home-grown socio-cultural contexts (MoH 1999). It requires tailoring to the contextual domains in the local areas such as culture, religion/spirituality, gender, and communication for effective social behavioural change among the cultural communities such as the Borana pastoralists (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome &Airhihenbuwa 2014; Airhihenbuwa 2007a). The World Bank Global HIV/AIDS Programme (2008) reported that HIV prevention programmes in Africa often prioritises the wrong targets, with a subsequent waste of resources, because of a basic lack of information on the target community. This is sometimes due to a dependence on observation or research that was conducted in the early stages of the epidemic which has not been updated. The dynamics and current situation on the spread of HIV/AIDS and the prevention mechanism is quite different from the 1999 situation in Ethiopia. The HIV/AIDS policy of Ethiopia overlooked the local contexts and changing realities of the target community at the bottom, including the pastoralists. The contextual gaps in the policy landscape would create gaps in the communication of HIV/AIDS among local communities like the Borana pastoralists.

8.5 THE CONTEXT OF THE HIV/AIDS POLICY OF ETHIOPIA

This theme addresses the HIV/AIDS policy context of Ethiopia. More specifically, this section analyses and presents the purpose and objective of the HIV/AIDS policy of Ethiopia in terms of its relevance to the local communities at the bottom. Furthermore, this theme analyses and presents the HIV/AIDS policy gaps in terms of the inclusion of contextual domains such as culture, gender, and religion/spirituality in the policy formulation.

8.5.1 Aligning objectives of the national HIV/AIDS policy of Ethiopia with the Indigenous context

Policy context is a background against which policy decisions are made, policy processes take place, and stakeholders or actors engage with the policy (Moat et al 2013). The national policy should consider the wider context, such as socio-cultural issues, to address the

existing problems (Bressers 2009). The national policy context should consider the geographical location and related local facilities in the target community for effective service delivery (Muthathi, Levin & Rispel 2020).The document analysis indicated that the HIV/AIDS policy of Ethiopia mainly considered the macro context at government level, which includes the political, economic and health institutions. The policy document analysis further pointed out that the micro contexts such as the socio-cultural context was not properly addressed in the policy material. This is consistent with the study by O'Reilly et al (2017) which reported that health policy implemented on a national level should fit into local contexts. The analysis confirms that preventing HIV/AIDS is the mandate of all stakeholders. However, the policy landscape did not properly address the role of local contexts, such as culture, for effective HIV/AIDS prevention. The findings of the document analysis confirmed that the general purpose of the HIV/AIDS policy of Ethiopia was to provide an enabling environment for the prevention and control of HIV/AIDS in the country (MoH 1999). The purpose was mainly to create an appropriate environment to prevent and control HIV/AIDS. According to the national policy document, the enabling environment implies political, economic and health environments (MoH 1999). As the document analysis shows, the objectives of the national HIV/AIDS policy of Ethiopia focused on the institutional factors, overlooking the contextual domains at the bottom. The multiple domain model discussed in Chapter 3, Part II, indicted that HIV/AIDS prevention is influenced by contextual factors outside the individuals. The national HIV/AIDS policy of Ethiopia should address the socio-cultural, gender, religious/spiritual, demographic, environmental and contextual variables in the specific pastoralist community of Borana (Zimmerman, Christaksi & Meltzoff 2007). HIV/AIDS policy programmes and communication approaches in Borana should not be removed from the urban culture (Dzimiri, Dzimiri & Batisai 2019).

Strategies to prevent HIV/AIDS need to consider the specific culture of the rural Borana pastoralists. Furthermore, the policy landscape should consider the social cohesion fostered by aspects such as religiosity, cultural ethos, and a community-based approach that play a key role in unifying people towards fighting HIV and AIDS in a collectivist cultural community like the Borana pastoralists (Dzimiri, Dzimiri & Batisai 2019). The following are the objectives of the HIV/AIDS policy (MoH 1999:25) considered for the analysis from the socio-cultural perspectives:

1. Establish effective HIV/AIDS prevention and mitigation strategies to curb the spread of the epidemic.

2. Promote a broad multi-sectoral response to HIV/AIDS, including more effective coordination and resource mobilisation by government, NGOs, the private sector, and communities.
3. Encourage government sectors, NGOs, the private sector, and communities to take measures to alleviate the social and economic impact of HIV/AIDS.
4. Support an institutional, home- and community-based healthcare and psychological environment for people living with HIV/AIDS and avoid discrimination against them.
5. Empower women, youth, and other vulnerable groups at risk to protect themselves against HIV/AIDS.
6. Promote and encourage research activities targeted toward preventive, curative, and rehabilitative aspects of HIV/AIDS.

The HIV/AIDS policy objectives affirm that the policy focussed on the institutional factors. The political, economic, and health institutions have been given due consideration in the policy formulation. The concept of stakeholders' coordination and collaboration referred to government institutions, NGOs, and donor organisations that could assist the policy implementation. However, the PEN-3 cultural health model affirms that the issue of HIV/AIDS prevention is not only about the structural issues. HIV/AIDS prevention should also consider the socio-cultural context in the local areas. In addition, the national HIV/AIDS policy objectives focussed on to the epidemiological aspects of HIV/AIDS disease prevention, treatment, and care (MoH 1999).However, the socio-cultural issues were overlooked in the broader national HIV/AIDS policy of Ethiopia. This has its own effect on properly tailoring HIV/AIDS communication to socio-cultural contexts at the bottom.

As indicated in the policy objectives (objective no.5), the national HIV/AIDS policy focuses the empowerment of women and youth and addressing the interests of the vulnerable population groups which is important and remarkable. However, the issue of gender from the context of the pastoralist population was overlooked both in the policy formulation and implementation. Gender inequalities and power relations in Africa reduce economic and social opportunities for better lives among women and increase risky sexual behaviour (Mbonye et al 2012). In Africa, the needs and desires of women are not considered significant and often women play no part in sexual decision making, nor are they allowed to express their sexuality (Ramjee & Daniels 2013). The purpose and objective of the HIV/AIDS policy of Ethiopia should be in line with the realities of the community at the bottom. More than 80% of the Ethiopian population live in the rural areas where culture plays a significant role in shaping the day-to-day life of the society.

The HIV/AIDS policy of Ethiopia considers women and youth empowerment which is crucial. This is a positive approach to address the interests of women via addressing the gender aspects that expose women to the risks of HIV/AIDS. However, like the in-depth interview and focus group interview data revealed, the national HIV/AIDS policy overlooked the unique characteristics in the pastoralist community such as mobility, conflict over grazing land, and long droughts that specifically affect women (Anbacha & Kjosavik 2019; Anbacha & Kjosavik 2019b). In addition, the HIV/AIDS policy formulation gave more focus to the non-pastoralist communities, like the urban population. This has its own limitation in understanding and addressing the interests of the pastoralist women. HIV/AIDS policy objectives need to consider the situations of the disadvantaged population like pastoralist women. The national policy objectives should consider the target population with unique features like the pastoralist community. This can be applied to the Borana pastoralist community where there is a need to contextualise HIV/AIDS programmes in terms of the pastoralist culture.

8.5.2 Re-thinking the contextual gaps of the Ethiopian HIV/AIDS policy

HIV/AIDS prevention should consider the importance of cultural variables such as the cultural norms and values of the target community (Mauro et al 2022). The study by Sovran (2013) reported that culture and HIV/AIDS in sub-Saharan Africa are interlinked and is difficult to isolate. However, the content of the national HIV/AIDS policy of Ethiopia lacks adequate attention to the cultural considerations at the bottom (MoH 1999). The political and economic institutions were given due emphasis in the policy consideration whereas the culture, gender, and religious/spiritual domains were not given significant attention at national policy level. Women and youth are mentioned in the policy as core areas of concern in the HIV/AIDS prevention. However, rural women in general (and pastoralist women specifically) are overlooked in HIV/AIDS prevention in practice. In the HIV/AIDS policy context, women in the urban areas can access better health services compared to the women in the rural areas. In formulating the HIV/AIDS policy of Ethiopia there was a gap in placing emphasis on the local contexts such as gender equality, regardless of the geographical location (Devon et al 2021; Maulide et al 2021; Ramjee & Daniels 2013; Mbonye et al 2012). Development interventions have long failed to accommodate the needs and preferences of pastoralists in Africa (Rogers et al 2021). Contextual domains in the pastoralist community such as pastoral culture, social networks, livelihoods, gender, environment, and climate change are not effectively articulated in the national HIV/AIDS policy document. The following diagram shows the contextual factors that should be considered in the HIV/AIDS policy of Ethiopia for effective HIV/AIDS prevention in Ethiopia.

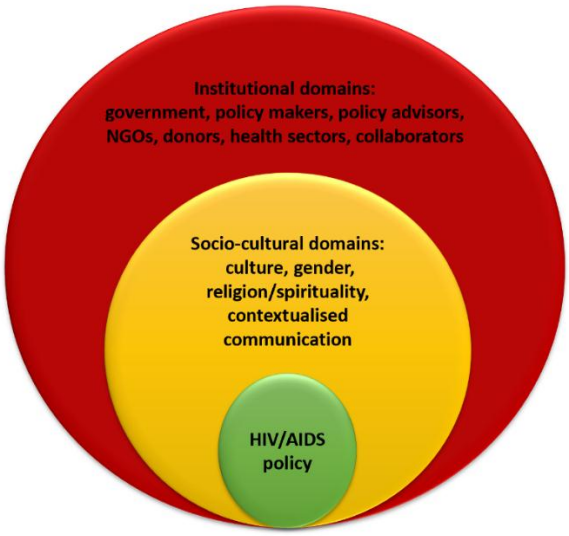


Figure 8.3: Focus of macro contexts in the national HIV/AIDS Policy of Ethiopia
Source: Developed by the author, based on Edwards and Barker (2014)

As the above figure indicates, political, economic, professionalism, donor-related contexts were given due attention in formulating the HIV/AIDS policy of Ethiopia. The document analysis asserted that cultural, gender, and religious/spiritual contexts were highlighted in the national HIV/AIDS policy of Ethiopia (MoH 1999). The national HIV/AIDS policy document articulates these contexts, mainly from the perspectives of the agrarian and urban community. However, the context in the non-agrarian community, like the pastoralist community of Borana, did not get adequate attention in the policy materials. Undermining the socio-cultural domains at the policy level had its own negative implication on the adequate implementation of the cultural approach to HIV/AIDS communication at the bottom. It is crucial to consider the cultural context when formulating the HIV/AIDS policy of Ethiopia for effective disease prevention that is locally relevant. This can be applied to the Borana pastoralist community where HIV/AIDS programmes and prevention strategy (which is drawn from the national HIV/AIDS policy), should consider the pastoralist contexts: environment, climate, and ways of life, religion/spirituality, gender, user-friendly language, cultural resources, and Indigenous institutions to combat HIV/AIDS effectively.

8.6 SOCIO-CULTURAL PERSPECTIVES OF THE HIV/AIDS POLICY CONTENT OF ETHIOPIA

This theme presents and analyses the content and communication strategies of the national HIV/AIDS policy of Ethiopia.

It considers whether the content of the national HIV/AIDS policy (and the communication strategies set in place) is appropriate to the context of an Ethiopian pastoralist community, like the Borana pastoralists. Policy content is the information contained within the policy document (Silverman 2006). Local cultural values and resources that can influence prevention education, as well as culturally appropriate content of sensitisation messages, is crucial to address HIV/AIDS communication (Silverman 2006:16). However, the national HIV/AIDS policy of Ethiopia focussed on control from the political, economic, and medical institutions (MoH 1999). The analysis further indicated that the policy content was mainly extrapolated from the western health policy. This means the policy formulation was influenced by the interests of the donor organisation like UNAIDS. The policy content formulation did not emanate from the context in the local areas of Ethiopia. In addition, the policy content development was a top-down approach that overlooked the contextual domains in the local community (MoH 1999). There was a lack of clarity and detailed strategies that consider the local context. The policy text did not clearly address the role of socio-cultural values, socio-demographic variables, or environmental and climate change issues to curb the spread of HIV/AIDS (MoH 1999). Religion is one key social and cultural factor with pervasive influence over the norms, values, structures, and institutions, which profoundly influences behaviour and decisions (Oman 2018). In contrast to this fact, the findings of the policy document analysis indicated that religious contexts were not adequately addressed in the HIV/AIDS policy document of Ethiopia. The impact of gender on HIV/AIDS demonstrates the importance of integrating gender into HIV programming and finding ways to support women by implementing policies and programmes that increase their access to education and information (Türmen 2003). However, the findings of the document analysis indicated that the HIV/AIDS policy of Ethiopia did not sufficiently consider the issue of gender inclusion and gender mainstreaming to prevent HIV/AIDS. It is therefore possible to infer that the national level HIV/AIDS policy content of Ethiopia overlooked the critical importance of culture, religion, and gender in preventing HIV/AIDS. There is a need to consider the contents of the national HIV/AIDS policy in terms of the home-grown context, other than depending on institutional factors such as politics, economics, and health institutions.

Communication scholars have long emphasised the need to recognise adherence to cultural norms of target communities as a catalyst for effective HIV/AIDS communication. Unfortunately, this call has not been totally heeded by the designers of HIV/AIDS communication instruments (Vitsupakorn, Pierce, & Ritchwood 2023; Uwah 201; Rujumba & Kwiringira 2010).

Airhihenbuwa and Webster (2004) argue that culture plays a vital role in determining the level of health of the individual, the family, and the community. This is particularly relevant in Africa, where the values of extended family and community significantly influence the behaviour of the individual. The health behaviour of the individual in relation to family and community is one major cultural factor that has implications on sexual behaviour and HIV/AIDS prevention and control efforts (Vitsupakorn, Pierce & Ritchwood 2023; Rujumba & Kwiringira 2010; Airhihenbuwa & Webster 2004).

In developing countries such as Ethiopia, the HIV/AIDS communication strategy was mainly driven from the public health information, education, and communication strategy that are western origin (Airhihenbuwa 2007). For effective health communication, understanding country-specific contexts are essential to compile an appropriate communication strategy. Health communication interventions should employ a variety of communication strategies to meet the interest of the target audiences (Berttrand et al 2012). The communication should use appropriate strategies such as electronic media, print media, social media, community outreach channels, and interpersonal communication to address the intended health objectives. Like the in-depth interview and FGI, the document analysis indicated that the communication strategy of the HIV/AIDS policy of Ethiopia did not clearly address how to use local communication opportunities such as cultural associations, social networks, cultural institutions, oral traditions/folklore, and other socio-cultural contexts in the community. The IEC approach mainly focused on the predetermined content and messages at national level. The policy communication approach was derived from the western IEC that focused on information dissemination. The following extract from the national HIV/AIDS policy of Ethiopia shows the focus given to information, education, and communication, without considering the wider contextual factors in the rural community:

> *Provision of IEC to all government sectoral ministries and institutions, non-governmental organisations, religious groups, professional associations and the community at large shall be given so that they can provide adequate attention to the problems of HIV/AIDS and fully participate in the prevention of HIV/AIDS. The Ministry of Health is hereby mandated to setup and coordinate this multispectral approach to respond effectively to the challenges of the epidemic* (MoH 1999:26).

The above extract reveals that, in the context of formulating the national HIV/AIDS policy of Ethiopia, contextual domains that would support the IEC of HIV/AIDS were overlooked(Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome &Airhihenbuwa 2014;

Airhihenbuwa 2007a).The document analysis showed that HIV/AIDS information, education, and communication targeted the general population in Ethiopia (MoH 1999). The communication strategies indicated how to establish links with the donor organisations, NGOs, inter-governmental agencies, government offices, and schools. This implies that the HIV/AIDS communication strategies at the policy level overlooked the interests of a specific target group like the pastoralist population in Ethiopia whose livelihoods require special policy attention.

In the Borana pastoralists community, where informal communication strategies and a cultural approach to communication dominates the day-to-day interaction of the community, it is unthinkable to bring social behavioural change depending only on the centrally developed mass media dominated communication strategies. Thus, overlooking the role of cultural approaches to HIV/AIDS communication in the national HIV/AIDS policy of Ethiopia would hamper effective HIV/AIDS message delivery. It is imperative that the national HIV/AIDS policy of Ethiopia should include communication strategies that are driven from the perspective of local contexts.

8.7 THE HIV/AIDS POLICY OF ETHIOPIA IN TERMS OF SOCIAL BEHAVIOURAL CHANGE

This theme focuses on analysing the consequences of the national HIV/AIDS policy of Ethiopia in terms of the policy's ability to bring social behavioural change. In addition, this section analyses and presents whether the national HIV/AIDS policy is tailored to the contextual domains in the local areas to bring effective social behavioural change. The Ethiopian government has a strong commitment to respond to HIV/AIDS through the enactment of a range of laws, policies, strategies, and the development of institutional responses. The government paid attention to the prevention and control of HIV/AIDS through condom use promotion and other HIV/AIDS prevention models. The MoH(1999) revealed that the HIV/AIDS policy of Ethiopia focused on protecting vulnerable populations such as people living with HIV, women and girls, commercial sex workers, young people, and long-distance truck drivers (Amare et al 2019). However, the findings of the document analysis indicated that the HIV/AIDS policy of Ethiopia did not consider the unique culture of pastoralism. This was confirmed by the study done by Amare et al (2019), which reported that HIV/AIDS detection, prevention, and treatment programmes in Ethiopia did not sufficiently consider the local contexts. The HIV/AIDS study in Ethiopia from 1990–2016 revealed that the country still has to tackle the emerging challenges of HIV/AIDS with due

consideration to the scenarios within the local community (Amare et al 2019). A paradigm shift from considering HIV/STIs as an individual concern, to larger policy and social structural factors is necessary for social behavioural change in a collectivist culture like the Borana (Mabweazara, Ley & Leach 2018). The document analysis asserted that Ethiopia worked towards the development of institutional responses in HIV/AIDS prevention, care, and treatment. The political commitment to address HIV/AIDS information, education, and communication was notable in the context of Ethiopia (Amare et al 2019). The health sectors in Ethiopia were also engaged in the fight against HIV/AIDS, in alignment with the government. The HIV/AIDS policy of Ethiopia mainly considered the institutional engagement. However, the document analysis indicated that the local contexts such as the positive socio-cultural and religious domains that would assist HIV/AIDS communication, did not get adequate attention in the national HIV/AIDS policy of Ethiopia. To bring about significant and sustainable change in HIV/AIDS prevention and control, apart from relying on government institutions, western policies, and donor interests, it requires the consideration of home-grown resources such as socio-cultural, religious/spiritual opportunities to limit the spread of the epidemic.

8.8 CONCLUSION

The document analysis indicated that the national HIV/AIDS policy of Ethiopia was influenced by the western models and theories of disease prevention, care, and treatment approaches. The in-depth interviews and FGIs indicated that the HIV/AIDS policy of Ethiopia focussed on the interests of the urban, educated class that has media exposure. This was corroborated by the findings of the document analysis. It is consistent with the study by Pavanello (2009) which revealed that pastoralists in sub-Saharan Africa have often been politically and economically marginalised in state policy which makes participatory processes especially difficult (Herrera, Davies & Baena 2014:4). In addition, Rogers et al (2021) stated that the viewpoints and interest of non-urban, non-sedentary demographics such as the pastoralists are excluded from the development policies formulation including HIV/AIDS.As reflected in the in-depth interviews and FGIs, the national HIV/AIDS policy of Ethiopia focussed on the general population and overlooked the specific context on the ground. In the HIV/AIDS policy formulation, contextual factors such as culture, gender, religion/spirituality, and communication approaches nearer to the community did not get adequate attention (Rogers et al 2021). HIV/AIDS interventions in the pastoralist regions like Borana were not well contextualised and integrated into to the needs of those underprivileged and marginalised populations (Serbessa et al 2016).

The documents analysis further indicated that the HIV/AIDS policy context of Ethiopia gave more focus to the macro contexts like politics, economy, professionalism, and the donor's role to prevent, care, and treat HIV/AIDS in Ethiopia. Furthermore, the document analysis indicated that the HIV/AIDS communication strategy of the national HIV/AIDS policy was top-down, persuasive, expert-based, and orientated towards individual behavioural change, which undermined the realities of aural context like the pastoralist culture. Therefore, the national HIV/AIDS policy of Ethiopia should consider the contextual domains in the community to address culturally appropriate HIV/AIDS messages among the cultural-bound communities of Ethiopia, like the Borana pastoralists. The next chapter (Chapter 9) concludes the study by focusing on the major points of the study.

CHAPTER 9
CONCLUSION

9.1 INTRODUCTION

This final chapter concludes the thesis and answers the research questions formulated in Chapter 1. The use of qualitative cross-sectional case study research design for in-depth understanding of the subject under the investigation was justified. Because of the nature of case study research, the study did not intend to generalise the findings to the general population, but to understand the socio-cultural appropriateness of HIV/AIDS communication among the Borana pastoralists in the Arero district, Borana, Ethiopia. The theoretical location of the study in the field of applied communication (health communication) was explained in terms of a socio-cultural approach to HIV/AIDS communication. Subsequently, the summary of the research questions and key findings of the study was provided based on the research objectives. The contribution of the study was briefly discussed, and recommendations were made in terms of future research, HIV/AIDS policy formulation, and an HIV/AIDS communication approach among the Borana pastoralists.

9.2 JUSTIFICATION OF THE QUALITATIVE CASE STUDY RESEARCH DESIGN

The use of a case study research design was effective in providing deeper understanding of the subject of the study, socio-cultural appropriateness of HIV/AIDS communication among the pastoralist community in Borana, Ethiopia. The case study helped to capture a range of perspectives regarding the socio-cultural embedment of HIV/AIDS communication. The qualitative study played a significant role to understand real-world contexts (Creswell & Creswell 2017; Yin 2009). The data for this study was collected in the field at the case study site, as explained in detail in Chapter 6 and Chapter 7 of this thesis. The use of multiple data sources namely in-depth interviews, focus group interviews, and document analysis helped to verify the reliability and validity of data and contributed to the data triangulation (Creswell & Creswell 2017; Yin 2009).

HIV/AIDS communication should coincide with the life context of the target audiences (Kaba, Ame & Mariam 2013; Dugassa 2014; Aguilar 2009). The in-depth research, or storytelling technique, was used to analyse individual stories regarding the cultural appropriateness of HIV/AIDS communication and behavioural changes among the Borana pastoralist

community (as indicated in Chapter 6). This method was essential to understand the lived experiences of individuals and the social group through a storytelling technique (Makalela 2015:4). This approach of data gathering assisted the exploration of the experiences of individuals such as cultural leaders, religious fathers, and healthcare workers concerning HIV/AIDS communication from the contextual domains such as cultural norms and values, traditions, languages, religion/spirituality and gender. The in-depth interviews were essential to understand the socio-cultural resources that either fuelled or banned the spread of HIV/AIDS in the study area. In addition, the individual interviews gave insight regarding the institutional gaps within the health system that affected effective HIV/AIDS communication. The in-depth approach was useful to make meaning out of the individual's stories by deconstructing and then reconstructing them again into meaningful narratives concerning the socio-cultural appropriateness of HIV/AIDS communication among the Borana pastoralists.

The FGIs were used to investigate the groups' lived experiences in the natural group conversations, concerning HIV/AIDS communication from the local context of the Borana pastoralist community (Du Plooy 2009:201). The FGIs were suitable for obtaining several perspectives about the embedment of HIV/AIDS communication in the socio-cultural, religious, and gender contexts of the Borana pastoralists (as indicated in Chapter 7). The FGIs gave insight into people's shared understandings of everyday life and the ways in which individuals were influenced by others in a group situation, especially concerning the topic of this study. The focus group interviews, in the natural conversation style, assisted in studying and explaining perspectives of different people within the community in relation to the research problems. It was important to explain and analyse group experiences regarding the embedment of HIV/AIDS communication into the contextual domains like culture, religion/spirituality, and gender. The FGIs were essential to develop an understanding about a culture-friendly HIV/AIDS communication approach that would suit the contexts of Borana pastoralists. They also gave important insight into the socio-cultural factors that hampered HIV/AIDS communication among the Borana pastoralist community. Furthermore, the group experiences in the FGIs helped to explain gaps in the communication approaches that overlooked the reality among the pastoral community in Borana.

Document analysis was one of data gathering tools. The HIV/AIDS policy of Ethiopia was analysed in line with the research objectives. As indicated in Chapter 8, the use of document analysis enabled the researcher to triangulate the data collected, supplementing the in-depth and focus group interviews.

Analysing the HIV/AIDS policy document was helpful to assess whether the national HIV/AIDS policy of Ethiopia paid attention to the contextual domains for effective HIV/AIDS prevention. In short, the documents analysis was crucial to provide supplementary data that could be seen at policy level concerning the topic of this study. The findings discussed in Chapters 6, 7 and 8 explained how multiple layers of data emerged throughout the inductive research process which involves the search for patterns from observation and the development of explanations and concepts related to this study. Generally, the use of qualitative research methods enables the researcher to obtain richer and deeper data as the researcher immersed himself in the field (Flick 2015:193). The qualitative research methods were validated by producing original and verified findings. The researcher was able to explore how socio-cultural factors play a vital role in HIV/AIDS communication. In addition, the qualitative study helped to get a deeper understanding about the disadvantages of relying on the western notion of disease prevention and communication approaches, which overlooked the collectivist culture and context of developing countries like Borana pastoralists in Ethiopia.

9.3 THEORETICAL BASIS OF THE STUDY

The theoretical basis for the study is rooted in the cultural approach to the HIV/AIDS communication framework. A theoretical framework is (usually) an integral part of research in social sciences. It explains the existing theories that support the research, showing that the work is grounded in established ideas. In other words, the theoretical basis of a study justifies and contextualises further research, and it is a crucial first step for a scientific research project. There are strategies that help to identify the theoretical basis of research work. According to Tsvere (2022) and Oladipo (2021), this is possible through:

- Examining the thesis title and research problem.
- Brainstorming on what the key variables in the research should be.
- Reviewing related literature to find answers to the research questions.

Though interdisciplinary in nature, this study was mainly positioned in the field of health communication and focused on the socio-cultural approaches to HIV/AIDS communication —a study to explain the socio-cultural dimensions of HIV/AIDS communication (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome &Airhihenbuwa 2014:5; Airhihenbuwa 2007a, Zimmerman, Christakis & Meltzoff 2007).

In line with this, the researcher used the notion of the PEN-3 cultural health model which explained that HIV/AIDS communication in Africa did not adequately consider the socio-cultural domains at the bottom (Iwelunmor, Newsome & Airhihenbuwa 2014:5; Airhihenbuwa 2007a).The HIV/AIDS communication was not conceptualised systematically to the context of the target population in developing countries (Douglas et al 2014:12).In addition, the multiple domain model was used to explain how contextual factors in the community influence health behaviour. This study contributes a conceptual framework of HIV/AIDS communication that promotes contextual domains such as culture, religion/spirituality, gender, linguistic, socio-demographic variables, environmental, climate factors, and user-friendly communication for effective HIV/AIDS communication and social behavioural change among the Borana pastoralist community.

The national HIV/AIDS communication should address the socio-cultural, gender, religious/spiritual, demographic, environmental and contextual variables in the specific population group (Zimmerman, Christakis & Meltzoff 2007). Health message reception is only effective if it is within the contextual domains of the target community (Foust & Taber 2023; Van Servellen 2009:23). HIV/AIDS is a trans-boundary problem; the problems of HIV/AIDS are beyond the health agenda. The medical approach of disease prevention alone cannot effectively address the problems of HIV/AIDS in the collectivist cultural society of the developing countries like Ethiopia. HIV/AIDS prevention calls for a contextualised approach, such as a culturally driven conceptual framework of communication, which was developed for this study, putting together perspectives, knowledge, and skills from different disciplines like health, culture, and communication. Such integrated perspectives call for participatory communication research, enabling all actors to be heard and to co-own a change process (HPCO 2008:3-4). Communication for behavioural and social change should incorporate aspects of research, monitoring, and evaluation (UNAIDS 2001:15). It is imperative to integrate different perspectives to address HIV/AIDS issues to ensure the significant relationship of the current topic to the field of communication. Health communication research, specifically the cultural approach to HIV/AIDS communication, helps to manage the high equivocality of healthcare and health promotion by responding to the socio-cultural and behavioural domains (Kreps 2020). Based on the findings of this study (Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa 2007a; Zimmerman, Christakis & Meltzoff 2007), the following are important insights:

- HIV/AIDS communication should give due consideration to culture, gender relations, religion/spirituality, and user-friendly communication.

- Positive attributes of a culture should be utilised in HIV/AIDS communication.
- Harmful cultural practices that hamper HIV/AIDS communication should be eliminated.
- HIV/AIDS communication, for behavioural and social change, needs to address community specificity.
- Familiar contexts, wherein both the sender and receiver of HIV/AIDS messages are relating to similar language, symbols, cultural codes and meaning, should be the foundation of communications interventions.
- Culturally informed HIV/AIDS policy programmes should consider the local contexts.

The researcher was able to integrate the notions of the PEN-3 cultural health model (Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa 2007a,) and the multiple domain model (Zimmerman, Christakis & Meltzoff 2007) with HIV/AIDS prevention to justify the positioning of this study in the field of applied communication in healthcare (HIV/AIDS prevention). This study has significant value in terms of contextualised communication in healthcare and HIV/AIDS prevention. The study provided important insight into the drawbacks of overlooking contextual domains such as culture, religion/spirituality, and gender in HIV/AIDS communication among Borana pastoralists. This study also contributed in terms of the problem of overlooking socio-epidemiological approaches of disease prevention, which considers the use of contextual factors such as socio-cultural, religion/spirituality and gender factors. Therefore, HIV/AIDS prevention should cater to the socio-cultural contexts (Iwelunmor, Newsome &Airhihenbuwa 2014:5; Airhihenbuwa 2007a, Zimmerman, Christakis & Meltzoff 2007). The study further pointed out the role of cultural resources such as Indigenous institutions and social networks in developing social health (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome &Airhihenbuwa 2014:5; Airhihenbuwa 2007a, Zimmerman, Christakis & Meltzoff 2007). More importantly, this study pointed out that the negative aspect of culture was over emphasised as a stumbling block to HIV/AIDS prevention, whereas the positive cultural opportunities were under-utilised to prevent the spread of HIV/AIDS in the study area. Most theories and models used within HIV/AIDS communication are western and based on social psychology that emphasises individuals (Azevedo & Azevedo 2017; Mukumbang et al 2017; Van Belle et al 2010; Freudenberg 2000; Obregon 2000:6). These western behavioural change models overlooked the collectivist culture in developing countries such as the Borana pastoralist (see Chapter 6).

HIV/AIDS communication among the Borana pastoralists emphasised the individual behavioural change more, which in fact failed to address the problem as intended.

The social behavioural change, which is participatory and considers the collectivist culture, was overlooked (Azevedo & Azevedo 2017; Mukumbang et al 2017; Van Belle et al 2010; Freudenberg 2000; Obregon 2000). The collectivist culture of the pastoralist community and their specific lifestyle was not emphasised; therefore, the communication did not bring about the intended social-behavioural change (see Chapters 6 and 7). The findings of this study show that HIV/AIDS communication approaches among the Borana pastoralist community was top-down, which did not give adequate attention to participatory communication. The health system did not consider the specific context and nature of the mobile pastoralist population. The system did not empower the local community to prevent the spread of HIV/AIDS by focusing on a user-friendly communication approach. The communication approach was not pastoralist friendly and mainly overemphasised the "what" of HIV/AIDS communication, rather than the "how". The HIV/AIDS policy of Ethiopia did not give adequate attention to the micro contexts like culture, religion, and gender. It was influenced by the donor's interest, emphasising the macro issues such as politics and economy (Rogers et al 2021; Serbessa et al 2016; Iwelunmor, Newsome & Airhihenbuwa 2014:5; Airhihenbuwa 2007a).

Generally, the research context of the study was reflected in the literature, which confirmed the researcher's argument of culturally embedded HIV/AIDS communication that suits the specific context of the target community of Borana pastoralists (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome & Airhihenbuwa 2014:5; Airhihenbuwa 2007a, Zimmerman, Christakis & Meltzoff 2007).The data confirmed that HIV/AIDS communication could be effective through understanding the contextual domains of the target community. In addition, giving attention to the socio-epidemiological aspects of HIV/AIDS prevention, revisiting the operation of the health system from the pastoralist contexts, looking at gender, mainstreaming the community-based HIV/AIDS programme, considering user-friendly communication approaches, rethinking social behavioural change models that consider the pastoralist contexts for effective HIV/AIDS communication is crucial.

9.4 SUMMARY OF THE RESEARCH QUESTIONS AND THE FINDINGS

This part of the thesis presented each research question together with the respective findings, literature, and the theory that guided the study.

9.4.1 Research Question 1: Does HIV/AIDS communication among the Borana pastoralists address the socio-cultural domains such as culture, religion/spirituality, and gender?

The research question intended to assess the socio-cultural embedment of HIV/AIDS communication among the Borana pastoralist community. The theoretical background of health communication in general, and socio-cultural approaches to HIV/AIDS communication, were reviewed and discussed in line with this question in Chapter 2(the context of HIV/AIDS in Africa, Ethiopia, and Borana) and Chapter 3, Part I (health communication, health promotion, and socio-cultural aspects of health communication). The theoretical background of contextualised health communication including HIV/AIDS communication was vital to understand culturally relevant HIV/AIDS communication to address the specific contexts of the target community. An effort to maintain or restore healthcare is not viable without contextualised communication. In addition, to treat illness effectively, the quality of communication determines treatment outcomes (Ishikawa & Kiuchi 2010:1-2). Effective communication between health professionals and the community at large is vital to ensure health. The paradigm shifts in health communication from solely epidemiological to an integrated social epidemiology plays a pivotal role to address public health properly. Healthcare should consider what is shared and what is specific, what is new to the existing culture and what is temporally embedded among a community (Banwell, Ulijaszek& Dickson 2013; Vermund & Hayes 2013; Goodwin 2015). Contextualised communication is a critical component of global efforts in health communication including HIV/AIDS prevention. Effective health communication is a primary tool in preventing the spread of AIDS.

Indigenous contexts are critical for effective messages construction (Airhihenbuwa 2000; Wanyoike 2011; Glanz, Rimer & Viswanath 2015). Similarly, the health communicator must consider cross-cultural implications in the choice of health messages. Socio-cultural values and beliefs should not be considered as a static force (Ahmad 2012:19). The HIV/AIDS prevention, treatment, and care programme must be embedded into the social contexts like culture, religion/spirituality, and the gender of the target community. Cultural familiarity often affects the way medical information is effectively communicated. HIV/AIDS programmes that are relevant to the socio-cultural contexts of a given community may not work for others (UNAIDS 2001; Prilutski 2010; Airhihenbuwa 2007b, 1995).

The findings confirmed that the harsh climatic conditions of the pastoral environments affected effective HIV/AIDS communication and health service delivery.

Long droughts and the harsh climate uniquely hampered HIV/ADS communication and the campaign strategies in Borana. The study asserted that HIV/AIDS communication area favours the highlanders. The lowlanders, pastoralists, were less considered when it came to accessing contextualised HIV/AIDS messages. HIV/AIDS communication and the campaign strategy were not fit for the contextual factors in the pastoralist ecology and the pastoralists' lifestyle (Rogers et al 2021).

Traditional practices such as *Jaala-Jaaltoo*, polygamy, female genital mutilation, widow inheritance, early marriage, and drug use (khat and alcohol) challenged HIV/AIDS communication. At the study site, having multiple sexual partners *via Jaala-Jaaltoo* sexual relations was considered a sign of pride, social relations, wealth accumulation, and land preservation for the generation. Widow inheritance remained culturally recognised, not only for sexual pleasure, but also to preserve the resources of the deceased husband. The study further asserted that polygamy was culturally recognised (with the decree passed by the *Gumii Gaayyoo* cultural assembly) to bear more children with less consideration to its implication on the spread of HIV/AIDS. The data indicated that, other than blaming the harmful cultural practices in the pastoralist community; the positive cultural resources such as the *Gadaa* cultural values were not well integrated into the community-based HIV/AIDS communication to develop societal health (Mapingure, Mukandavire& Chingombe 2021; Munyaradzi et al 2016). The faith-based organisations and socio-cultural institutions such as *Gadaa, Qaalluu*, as well as the *Gumii Gaayyoo*, were not properly used to ban the spread of HIV/AIDS (Rogers et al 2021; Serbessa et al 2016). HIV/AIDS communication was not conceptualised systematically to the contexts of the target population in Borana (Douglas et al 2014:12).

The social networks such as *Buusaa, Gonofaa*, and *Marroo* that serve the pastoralists community to withstand risks due to droughts, famine, and displacements were not well utilised to prevent the spread of HIV/AIDS. The Indigenous institutions nearer to the local community were overlooked to curb the problems of HIV/AIDS. Borana oral traditions (oral stories) were not adequately integrated into HIV/AIDS communication to inculcate moral lessons. The social and behavioural sciences of disease prevention such as Indigenous institutions, social networks, culture, arts, and oral traditions were unnoticed. Religious resources were among the local opportunities to address HIV/AIDS messages. However, beliefs such as faith healing, holy water, herbal medicine, and fortune-tellers continued hampering HIV/AIDS message reception among the Borana pastoralists.

The Holy Spirit and holy water were believed to prevent and cure HIV/AIDS. HIV/AIDS communication strategies did not challenge the ill practices that expose the community to HIV/AIDS risks.

The study confirmed that HIV/AIDS communication materials were not originally developed from the specific context of the Borana pastoralists. The communication materials did not consider the Borana dialects and cultural symbols. The materials were translated to the native language of Borana, Afan Oromo, from other languages liker Amharic. Such translated materials lacked originality of language, contextualised examples, lived experiences of the pastoral community, and the cultural flavour and texture quality to address the pastoralists' reality. The print products such as posters, brochures, and pamphlets in the health posts were not appropriate to the pastoralists' cultural contexts and literacy level, which could create communication barriers. The language of HIV/AIDS communication focused on the masculine gender and gender biased language. The art of communicating HIV/AIDS messages using Borana oral traditions and arts was undermined. Thus, the health message delivery system was not properly tailored to Borana folk culture like fables, proverbs, cultural theatre, cultural songs, cultural symbols, or artefacts (Rogers et al 2021; Khandu, Tobgay & McFarland et al 2021; Mtenga et al 2018; Serbessa et al 2016; Iwelunmor, Newsome & Airhihenbuwa 2014:5; Airhihenbuwa 2007a).

Borana pastoralist women had no equal rights with the men. Women were less considered in the social, economic, and political affairs (Amare et al 2019; Kenea 2019; Anbacha & Kjosavik 2019; Anbacha & Kjosavik 2019b). The Borana *Gadaa* socio-cultural and political system favours the men over the women. The gender inequality affected the rights of women, including sexual rights. Gender inequality exposed women to harmful practices such as gender-based violence, early marriage, and girls' school dropouts, migration, and commercial sex (Girum et al 2018; Kaba, Ame & Mariam 2013; Serbessa et al 2016). The pastoralist women were more responsible for the domestic activities and had no equal chance to access HIV/AIDS information. Men had more opportunity to access HIV/AIDS messages and making decisions related to sex and marriage was mainly reserved for men (husbands). HIV/AIDS communication among the pastoralist community did not adequately address the gender gap regarding sexual decisions to prevent HIV/AIDS (Anbacha & Kjosavik 2019b; Bryceson 2019; Wangui 2008; Kaba, Ame & Mariam 2013).

HIV/AIDS communication in developing countries within Africa should consider the micro contexts such as culture, religion/spirituality and gender issues (Khandu, Tobgay &

McFarland 2021; Mtenga et al 2018; Serbessa et al 2016; Bastien, Kajula& Muhwezi 2011; Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa 2007a).The communication should consider, not only the medical aspects of HIV/AIDS prevention, but also the social and behavioural dimensions for effective disease prevention(Ndlovu 2023; Agustina et al 2023; Rampton, Böhmer & Winkler 2022; Mokhutso 2021; Whitelaw & Clark 2019; Vermund, Van Lith & Holtgrave 2014). Yet, HIV/AIDS communication among the Borana pastoralists overlooked the contextual domains at the bottom.

The unique cultural opportunities such as the Gadaa cultural values were not properly integrated into the HIV/AIDS prevention strategies. HIV/AIDS communication was top-down so that the role of opinion leaders, such as cultural leaders and religious fathers, were inadequate in designing and communicating health messages to influence societal behaviour concerning HIV/AIDS. The deep-rooted cultural and religious beliefs and practices, as well as gender relations, that exacerbate the spread of HIV/AIDS were not challenged through participatory, bottom-up, and pastoralist-friendly HIV/AIDS programme planning and execution. The findings from the document analysis (MoH 1999) indicated that the HIV/AIDS policy of Ethiopia did not focus on the home-grown socio-cultural domains (see Chapter 8). The national HIV/AIDS policy of Ethiopia overlooked the underprivileged population groups like the pastoralist community (MoH 1999). It did not adequately consider the local socio-cultural values, norms, belief system, and Indigenous resources. The HIV/AIDS policy formulation was influenced by the western health models and theories as well as the donor's interests.

9.4.2 Research Question 2: What is the practice among the Borana pastoralist community in relation to the community-based HIV/AIDS communication?

This research question was mainly to assess the behavioural change among the Borana pastoralist community. The central idea of the research question was whether Borana pastoralists brought about the intended behavioural change by avoiding harmful practices, beliefs, and expectations that fuel the spread of HIV/AIDS. The literature reviewed in Chapter2, Chapter3, Part I and Part II, indicated that health communication in sub-Saharan Africa overlooked the contextual domains for social behavioural change (Ndlovu 2023; Agustina et al 2023; Rampton, Bömher & Winkler 2022; Mokhutso 2021; Whitelaw & Clark 2019; Vermund Van Lith & Holtgrave 2014; Bastien, Kjula & Muhwezi 2011). It further acknowledged the importance of the contextual domains in HIV/AIDS communication. The inter-related literature works (Chapter 2, Chapter 3, Part I and Part II) indicated that

behavioural change has been responsible for the disease prevention successes to date. However, strategies to modify HIV/AIDS risk behaviours remain a priority for HIV/AIDS prevention in sub-Saharan Africa (Khandu, Tobgay & McFarland 2021). Behavioural strategies concerning HIV/AIDS are those that attempt to avoid unsafe sexual intercourse, decrease the number of sexual partners, test for HIV, encourage adherence to biomedical strategies preventing HIV transmission, decrease the sharing of needles and syringes, and decrease substance use and harmful beliefs and practices. Behavioural change strategies to accomplish these goals should focus on the entire community in the context of the collectivist culture of sub-Saharan Africa. The socio-cultural, religious/spiritual, and gender contexts that hamper the intended behavioural change should be identified and tackled (Adia et al 2019; Watson 2014). Behavioural strategies attempt to motivate behavioural change within social units by use of a range of community normative approaches (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa 2007a; Zimmerman, Christakis & Meltzoff 2007). Accordingly, there was resistance to change the established practices such as early marriage, polygamy, extramarital sexual networks, and widow inheritance among the pastoralist community. A sexual network such as *Jaala-Jaaltoo* was culturally recognised not only as a means of sexual pleasure, but also for promoting social ties among the clans. Polygamy was still in practice, as culturally recognised sexual norm to bear more children, especially sons, to preserve the Borana land for the generation to come as the land inheritance right is culturally given to men, not women. Widow inheritance, usually by a brother of the deceased husband, helped to maintain the social and economic welfare of widows and orphans. The practice of early marriage among most of the pastoralist community exposed younger women to the problem of HIV/AIDS as they were less likely to insist on safe sexual practices such as condom use and testing for HIV/AIDS before sex. The traditional livestock market had its own contribution to exposing the pastoralists, especially men, to the risks of HIV/AIDS. Female genital mutilation was practised in secret, which did not consider HIV/AIDS transmission. Female circumcision was a way to protect against sexual alertness before marriage. The socio-cultural factors remained an obstacle to the intended social behavioural change, regardless of HIV/AIDS communication taking place in the pastoral community (Monod et al 2023; Thorp et al 2023; Robert et al 2020; Logie et al 2019; WHO 2018).

Sub-Saharan Africa embraces a rich diversity of Indigenous and religious traditions (Mapingure, Mukandavire & Chingombe 2021; Rapaport et al 2023; Khandu, Tobgay & McFarland2021; Mabweazara, Ley & Leach 2018; UNAIDS 2016; Shaw& El-Bassel 2014).

Since moral behavioural proscriptions often trace their sources to religious teachings, religion and a strong adherence to religious principles have been thought to provide protection against HIV/AIDS transmission (Agha et al 2006; Lagarde et al 2000; Trinitapoli & Regnerus 2006). The findings indicated that there is a belief that HIV/AIDS was sent from God and that the disease was considered an urban disease. There were pastoralist women who believed pastoralist men, who usually move to towns for the livestock market and have sexual intercourse with other women in the town, were responsible for the spread of HIV/AIDS.

The cultural leaders (as explained in Chapter 6) accepted that HIV/AIDS could not bother Borana due to *Waaqaa* (God)'s protection. The findings further indicated that faith healing, the use of herbal medicine, and consulting fortune-tellers continued to be practised among the pastoral community. The Holy Spirit and holy water were believed to prevent and cure HIV/AIDS. Drugs such as khat and alcohol is used which leads to unprotected sex. The findings further indicated that some religious institutions and doctrine encouraged polygamy, which had been practised among their respective followers. Like the harmful cultural practices, there were religious/spiritual beliefs and practices that limited the social behavioural change regarding HIV/AIDS prevention.

Culturally sanctioned gender relations have an especially prominent role in the HIV/AIDS epidemic in sub-Saharan Africa, where HIV rates in women substantially exceed those in men (UNAIDS 2008). In the literature, gender is understood as the social role occupied by each sex, and gender relations as the interactions between these two social roles. The relative status of women in society in general, and in their intimate relationships can strongly influence the chances of being infected (McCarthy 1996) and is a common theme in the literature. As explained in RQ1 above, the Borana pastoralist women have no equal rights. Women were less considered in the social, economic, and political affairs. In fact, gender inequality has been accused of being the primary factor that determines patterns of HIV/AIDS in Africa (Niëns & Lowery 2009). HIV/AIDS should consider the ideas of the PEN-3 cultural health model (Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa 2007a) that focuses the contextual factors in the community such as gender issues (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa 2007a; Zimmerman, Christakis & Meltzoff 2007). In addition, the conceptual framework developed for this study revealed that HIV/AIDS prevention in Borana should follow the socio-cultural path for effective social behavioural change to occur.

The findings indicated that pastoralist women find themselves in a subordinate position to men. Women (wives) were unable to refuse unsafe sexual practices, insist on condom use, polygamy, widow inheritance, or extramarital sexual relations. The gender inequality in the pastoralist community affected the rights of women, which exclusively exposed them to harmful practices such as gender-based violence, early marriage, wrongful sexual decision; girls school dropouts, migration, and commercial sex. The culturally constructed gender roles and expectations remained an obstacle to the intended social behavioural change. The findings indicated that the cultural integration of HIV/AIDS communication among the pastoralist community was not adequate and insignificant in practice.

Generally, behavioural change practices among the pastoralist community of Borana was hampered by the deep-rooted perceptions, attitudes, and belief systems emanating from cultural, religious/spiritual, and gender dimensions. Additionally, HIV/AIDS communication did not consider the pastoralist contexts and therefore the desired social behavioural change was not achieved among the community. Basing the notion of the PEN-3 cultural model, the multiple domain models, and the conceptual framework developed for this study, HIV/AIDS prevention in Borana should follow the socio-cultural path for effective social behavioural change to occur.

9.4.3 Research Question 3: What is considered acceptable and culturally appropriate HIV/AIDS communication approaches for the Borana pastoralist community?

This research question was mainly to assess culturally appropriate HIV/AIDS communication approaches that suit the local reality of Borana pastoralists. In addition, the research question intended to examine whether the HIV/AIDS communication considered the local communication opportunities for effective message delivery. Culturally sensitive health communication in general, as well as HIV/AIDS communication, is about understanding and promoting the communication needs of the target community (Claramita et al 2016; Douglas et al 2011). Cultural sensitivity to communication is about critical reflection on values, beliefs, preferences and culture, traditions, perspectives and practices of culturally diverse individuals, families, and communities (Douglas et al 2011). The health communication models and theories reviewed in this study included: the health belief model (Glanz, Rimer &Viswanath 2015), the theory of reasoned action (Fishbein & Ajzen 1975), diffusion innovation theory (Rogers 1983), the social learning/cognitive theory (Bandura 1986), the social marketing theory (Guttmann 1997b), the trans-theoretical model (Kaufman et al 2014), and the multiple domain model (Zimmerman, Christakis & Meltzoff 2007).

These models emphasised individual's behaviour in health communication and focused on factors such as knowledge, beliefs, attitudes, practices, and rational thinking of individuals (Glanz 2005). The western health behavioural models and theories have been criticised for overlooking the contextual domains in developing countries (Okechi 2018; Iwelunmor, Newsome & Airhihenbuwa 2014:5; Moola 2010:43).

The behavioural theories and models commonly used in health communication and promotion were based on the behaviour and decision-making process of so-called rational individuals. Individuals were assumed reasonable to accept HIV/AIDS messages and bring about the intended behavioural change. This does not work for the Borana pastoralist community where individual decisions are influenced by group decisions (Obregon 2000:10-15). The adoption of western models based on individual behavioural change, individual rational thinking, and self-efficacy cannot address the contexts of the collectivist cultural society of Africa (Obregon 2000:6). Many communities in Africa, such as the Borana pastoralists, are more collectivistic and directly applying the western concept of behavioural change is challenging (McKee & Becker 2004:41). There is an urgent need to make a shift from behavioural models and theories to cultural models to prevent the spread of HIV/AIDS. As a result, developing a cultural HIV/AIDS communication framework for the Borana pastoralist community is vital.

The PEN-3 cultural model (Iwelunmor, Newsome & Airhihenbuwa 2014) was reviewed to substantiate this need for contextualised HIV/AIDS communication among the Borana pastoralist community. This is because the PEN-3 cultural model offers an organising frame to centralise culture when defining health problems and framing their solutions (Airhihenbuwa 2007a, 2007b, 1995). The idea of the PEN-3 cultural model is that individual perceptions and actions regarding health are shaped and defined by their cultural beliefs and practices (Airhihenbuwa 2007a). For effective health communication, understanding the issues of cultural identity, relationships, and expectations, as well as cultural empowerment of the target community is critical. This implies the cultural model offers an organising frame to centralise culture when defining health problems and framing their solutions (Airhihenbuwa 2007a, 2007b, 1995). Additionally, the PEN-3 cultural model advocates the importance of considering cultural sensitivity and community participation to address culturally appropriate health messages. As a result, reviewing the PEN-3 cultural model for this study was relevant to promote HIV/AIDS communication that is anchored in culture. The cultural model advocates for the involvement of communities in health education, information, and communication programmes.

The literature discussed in Chapter 3, Part II indicated that the PEN-3 cultural model is considered for Africa to situate culture at the centre of determinants of health behaviour (Cowdery, Parker & Thompson 2010). This model argued culture should be a supporter and should not be singled out as the explanation for the failure of a health intervention. Concerning HIV/AIDS, culture can also be viewed in terms of its strengths and attributes that are helpful in HIV/AIDS prevention, care, and support. HIV/AIDS communication should not focus only on the negative aspects of cultural practices but should also consider the positive aspects of culture for disease prevention (Airhihenbuwa 2007b).In addition, the idea of the multiple domain models is crucial to explain HIV/AIDS communication scenarios in Borana. This model explained that HIV/AIDS prevention is influenced by contextual factors outside of the individuals (Zimmerman, Christakis & Meltzoff2007). HIV/AIDS communication needs to consider the contextual variables in the pastoralist community. Additionally, the conceptual framework developed for the Borana pastoralists (Chapter 4) should be considered for effective integration of HIV/AIDS communication and prevention strategies with the socio-cultural, gender, religious/spiritual and community-based communication contexts of the Borana pastoralists.

The literature in Chapter 3, Part II, stated that HIV/AIDS communication in developing countries within Africa was influenced by the western communication models and behavioural change theories (Airhihenbuwa 2007b, 2000, 1995). The health communication models and theories, mainly borrowed from the field of social psychology, were not enough as they were driven from western individualistic points of view (Iwelunmor, Newsome & Airhihenbuwa 2014; Uwah 2013; Airhihenbuwa 2007b). The behavioural models and theories were mainly based on the western values, norms, belief, culture, and world views which might contradict the African realities. The health communication models and theories reviewed in Chapter 3, Part II, concluded that none of these models were enough to address the cultural appropriate HIV/AIDS communication in the context of Africa. Yet, the PEN-3 cultural model was crucial in the sense that it advocates HIV/AIDS communication where culture plays the central role. This model gives the opportunity to see beyond the western paradigm of health development and promote culturally appropriate HIV/AIDS communication in African contexts (Airhihenbuwa 1995).

HIV/AIDS information dissemination cannot be isolated from the cultural factors that shape the context in which it occurs. Thus, the disproportionate impact of health crises, like those that HIV/AIDS have on communities that are already marginalised, highlights the importance of engaging with health information dissemination considering culture and contextual

structures that enable or constrain health behaviour (Rivera & Fothergill 2021). Chapter 4 formed the basis of the conceptual contribution and clearly indicated the need for pastoralist-specific HIV/AIDS communication approaches that fit the contextual domains of the target community.

The findings indicated that HIV/AIDS communication among the Borana pastoralist community overlooked the cultural path of communication. This means the communication strategy did not notice the collectivist culture of Borana (Adia et al 2019). As a result, HIV/AIDS prevention strategies among the pastoralist community mainly followed the epidemiological (medical) approach, overlooking the role of cultural, religious/spiritual, gender and communication contexts. The communication approaches focused more on the individuals and/or affiliated community groups. The communication was influenced by the western behavioural models, which failed to consider the communalities in a cultural community, such as the Borana pastoralists (Rogers et al 2021; Uwah 2013). HIV/AIDS education, information, and communication intended to impart medical knowledge of the epidemic without considering the socio-epidemiological aspects of HIV/AIDS.

The findings further revealed that HIV/AIDS communication among the Borana pastoralists was mainly top-down. The health workers were more familiar with the kind of communication that channelled from the source (health workers, government officials) to the individuals/affiliated community groups. The communication path should consider the opinion leaders, larger pastoralist community, the family institutions, and individuals (Rogers et al 2021; Adia et al 2019; WHO 2018; Serbessa et al 2016; Edwards & Barker 2014).HIV/AIDS message design and communication strategies were not inclusive and participatory from the onset. Macro level issues such as national politics and the economy mainly influenced the HIV/AIDS programme. The micro aspects of HIV/AIDS communication such as the local domains (culture, gender, language, religion, environments) did not get adequate attention in the policy formulation. The national HIV/AIDS policy, message design, and communication strategies did not adequately consider the local community to develop their own health programmes via the use of positive socio-cultural resources.

The findings further asserted that HIV/AIDS communication models in practise were more persuasive and unidirectional in nature which undermined the positive aspects of a conversational, two-way, and symmetrical communication culture (Belay et al 2022; Adia et al 2019; Davis et al 2015; Iwelunmor, Newsome & Airhihenbuwa 2014). The propaganda model of political communication and one-sided persuasive communication seemed to be

reflected in the HIV/AIDS communication. The dominant HIV/AIDS communication models in practise were mainly the western individual behavioural change models which overlooked the collectivist culture of Africa (Airhihenbuwa 2007b, 2000, 1995). The communication focused more on the knowledge domains of behavioural theories. The communication interest of health workers was mainly to persuade the community/clients to accept the predetermined HIV/AIDS messages. Predetermined behavioural outcome concerning HIV/AIDS prevention was emphasised. Innovative ways of participatory HIV/AIDS communication that integrate Indigenous resources and cultural opportunities were overlooked.

The findings indicated that the taboo topic of sex continued to hamper condom promotion in the pastoralist community. The unique cultural institutions and social networks such as *Gadaa, Gumii Gaayyoo, Qaalluu, Buusaa-Gonofaa*, and *Marroo* were not adequately utilised to communicate the problems of HIV/AIDS. The social marketing model to promote condom use was not integrated with the cultural values and norms of the community at the bottom. The activities to promote condom use among the pastoralists followed a similar path than that of condom promotion in the urban and semi-urban areas. This overlooked the unique features of the more mobile and culturally bound pastoralists.

The in-depth interview data (Chapter 6) further asserted that non-health professionals (politicians) used to intervene in the community-based health communication, including HIV/AIDS communication, in the study area. Politically affiliated individuals/groups used to have the lion's share in the community level HIV/AIDS conversations. The participants' community-based HIV/AIDS meetings, conversations, and forums were mainly held by local political leaders. Politicians had significant share to decide who should participate in the community affairs mainly from the political points of view. The day-to-day activities of healthcare workers such as health extension workers were evaluated not only in terms of professional competency, but also in terms of political affairs. Thus, HIV/AIDS communication among the Borana pastoralists should follow locally relevant socio-cultural paths that integrate contexts such as culture, religion/spirituality, gender, language, social networks, and institutions. Pastoralist-specific health system; pastoralist–friendly HIV/AIDS communication approach is vital to bring social behavioural change.

9.4.4 Research Question 4: Does the HIV/AIDS policy of Ethiopia address the socio-cultural contexts of the Borana pastoralist community?

This research question was mainly to assess whether the national HIV/AIDS policy of Ethiopia gave appropriate attention to the socio-cultural contexts which has a significant impact on the societal health development and disease prevention. The literature in Chapter 2 indicated that the pastoralist community in East Africa remain socially and economically marginalised and have little representation in local and national government (Catley 2017). Most governments in East Africa continue to hold that pastoralism is unsustainable and a barrier to development (Catley 2017). Pastoralists are the most politically marginalised group in the Horn of Africa and East Africa (Carrington 2019; Oxfam 2008). The livelihoods of pastoralists depend on their knowledge of the surrounding ecosystem and on the well-being of their livestock (Tefera & Shewadeg 2022; Truebswasser & Flintan 2018). Poor socio-economic status, harmful traditional practices and scarce health infrastructure contribute to the continuing HIV/AIDS risks among the pastoralist community. HIV/AIDS interventions among the pastoralist community of East Africa require the provision of appropriate health services and understanding the context within the community (Serbessa et al 2016; Herrero et al 2016). HIV/AIDS policies should consider the contextual factors operating within the economic, political, and socio-cultural spheres of the respective countries (Rogers et al 2021; Edwards & Barker 2014).

The findings of the document analysis affirm that the HIV/AIDS policy of Ethiopia was influenced by the international funding organisations and foreign interests. The success of Ethiopia's HIV/AIDS response has largely been driven by external funding from development partners, particularly the United States. The analysis further indicated that the policy context was taken from the western health policy. This means the policy formulation was influenced by the interest of the donor organisations like the USAID. The policy context and content did not emanate from the socio-cultural perspectives of the local areas. African health systems are inflexible because of powerful international donors that cases fragmented health efforts while undermining local systems (Sama & Nguyen 2008). Developing countries primarily rely on international donors' support and interests in developing their policies, including health. However, lack of strong citizens' participation in the development policies like the HIV/AIDS policy affects the ability to create country-specific context in Africa (O'Reilly et al 2017). HIV/AIDS policy interventions in the pastoralist regions of East Africa, like Ethiopia, were not well contextualised and integrated into the needs of those impoverished populations (Serbessa et al 2016). The home-grown national HIV/AIDS policy that is based on the contextual domains in the local areas is crucial to bring social behavioural change in the local community (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome &Airhihenbuwa 2014; Airhihenbuwa 2007a).

The findings indicated that the national HIV/AIDS policy of Ethiopia focussed on the population group who had access to media information. The policy focussed on the interests of the urban, educated class. Health literacy, including people's abilities to access, process, and comprehend health-related information, has become an important component in the management of complex and chronic diseases such as HIV/AIDS infection (Mgbako, Conard & Mellins 2022). The HIV/AIDS prevention programme among the pastoralist populations should consider the literacy rate (Tasah 2021). Pastoralists in sub-Saharan Africa have often been politically and economically marginalised in state policy which makes participatory processes especially difficult (Rogers et al 2021; Herrera, Davies & Baena 2014; Pavanello 2009). The viewpoints and interest of non-urban, non-sedentary demographics such as the pastoralists are excluded from the development policies formulation, including HIV/AIDS (Rogers et al 2021).

The national HIV/AIDS policy of Ethiopia focused on the macro contexts such as the economic and political issues in the policy formulation and implementation (MoH 1999). The health policy of Africa relied on a simplistic approach that overlooked the complexity of overlapping (and often contested) issues in the cultural community (Rogers et al 2021). The roles of socio-cultural domains which are essential to address HIV/AIDS were not well addressed in the national HIV/AIDS policy document (Rogers et al 2021; Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome & Airhihenbuwa 2014; Airhihenbuwa 2007a). The document analysis confirms that the roles and responsibilities of different bodies such as opinion leaders, elders, religious people, and socio-cultural institutions were not clearly stated. The HIV/AIDS policy document overlooked the nature of a collectivist culture where development effort is influenced by the contextual domains in the local areas (Adia et al 2019). In addition, the policy formulation followed the top-down approach that overlooked the contextual domains (MoH 1999). There was a lack of clarity and detailed strategies that considered the local contexts such as culture, religion/spirituality, gender, and user-friendly communications in the national HIV/AIDS policy of Ethiopia. Contextual factors, such as cultures of collectivism versus individualism, shape HIV/AIDS coping strategies in Africa (Adia et al 2019). The HIV/AIDS policy needs to consider the notion of the PEN-3 cultural health model (Chapter 3, Part II). According to this model, HIV/AIDS communication in the collectivist culture of Africa should consider the socio-cultural contexts of the specific community (Khandu, Tobgay & McFarland 2021; Iwelunmor, Newsome &Airhihenbuwa 2014; Airhihenbuwa 2007a). The national HIV/AIDS policy should address the socio-cultural, gender, religious/spiritual, demographic, environmental, and contextual variables in the specific population group (Zimmerman, Christakis & Meltzoff 2007).

The findings of the policy document analysis asserted that the HIV/AIDS policy of Ethiopia overlooked the pastoralist livelihoods (Rogers et al 2021). It did not consider the unique circumstances of the underprivileged, marginalised population like the pastoralists that need special policy attention (Rogers et al 2021). The HIV/AIDS policy context should consider the geographical location and related local facilities in the target community for effective service delivery (Muthathi, Levin &Rispel 2020). According to the findings of the document analysis, the HIV/AIDS policy of Ethiopia emphasised the issues of medical epidemiology concerning HIV/AIDS prevention, care, and treatment (MoH 1999). There was a lack of clarity and detailed strategies that consider the significance of socio-cultural determinants of health (Jahagirdar et al 2021; Nweze et al 2018; Rodríguez et al 2017; Audet et al 2010). Beyond ART, condom promotion related to sexual behaviours, social determinants and awareness also assisted in influencing the HIV/AIDS epidemic (Jahagirdar et al 2021). The policy formulation needs to consider the contextual factors operating within the socio-cultural spheres of the respective countries (Edwards & Barker 2014). The national HIV/AIDS policy of Ethiopia should address issues in the local areas of the pastoral population such as socio-demographic, environmental, and climate change variables (Zimmerman, Christakis & Meltzoff 2007). The findings of the document analysis indicated that there was a lack of locally informed HIV/AIDS communication approaches. The policy materials overlooked the role alternative and locally informed health communication approaches to bring effective social behavioural change. The policy document did not have a clear and networked socio-cultural and home-based communication strategy to create conducive environments to prevent and control HIV/AIDS. The policy was influenced by the western health behavioural models which focussed on the individual's rational thinking to bring positive health behaviour.

9.5 CONTRIBUTION OF THE STUDY

This study expands on the notion of a cultural approach to HIV/AIDS communication based on the qualitative data collected from the Borana pastoralist community in Borana, Ethiopia via a cross sectional case study design. The study challenged the western notion of HIV/AIDS communication, which overlooks the contextual domains in the collectivist cultural societies of the developing countries such as the pastoralists in Borana, Ethiopia. While contributing a user-friendly conceptual framework, cultural path of HIV/AIDS communication and prevention, this study provided input that HIV/AIDS among the pastoralist community

should focus on the unique characteristics of pastoralism as well as community level contexts (a collective culture) for social behavioural change.

The in-depth qualitative data explained how a cultural path of HIV/AIDS communication contributes to effective health service delivery in the collectivist, culturally bounded pastoralist community. The study contributed to the notion of a bottom-up HIV/AIDS prevention that should consider both epidemiological and the socio-epidemiological aspects of HIV/AIDS prevention such as culture, religion/spirituality, gender, and a user-friendly communication approach (Jahagirdar et al 2021; Nweze et al 2018; Rodríguez et al 2017; Audet et al 2010). The study made a unique contribution as it indicated innovative concepts of adjusting health systems to the specific environmental situations and the lifestyle of a target community such as the Borana pastoralists. This study further contributes to the existing body of knowledge in the field of health communication in the form of developing a culturally driven conceptual framework. A conceptual framework and a cultural path of HIV/AIDS communication was developed from literature, which could help to promote a socio-cultural approach to HIV/AIDS communication among the Borana pastoralist community in Ethiopia. The cultural model and theories support the significance of contextual factors such as culture, religion/spirituality, gender, and user-friendly communication to address effective HIV/AIDS communication (as discussed in Chapter 4).

Ethiopia is known for its diversities (for example, ethics and linguistics), and deep-rooted socio-cultural, religious/spiritual practices, and intuitions(Vigliotti et al 2020; Gesesew et al 2020; Adal 2019; Teklehaimanot et al 2016; Kloos et al 2013; Lakew et al 2015) .However, the HIV/AIDS policy of Ethiopia, influenced by the donor's interests, gave more focus to the macro institutions (economy and politics) while overlooking the role of contextual factors (culture, religion, gender and communication). As indicated in Chapter 1, a gap was observed in integrating HIV/AIDS communication with the contextual domains of the target community in Ethiopia for effective message delivery. In a diverse country like Ethiopia, socio-cultural, religious/spiritual, gender, and communication contexts need to be considered by the medical system to address the local realities.

This study also contributed toward the limited research in the area of a cultural approach to HIV/AIDS communication for the underprivileged, culturally bound, environmentally disadvantaged, mobile population such as the pastoralists. As discussed in the literature review of Chapter 1, HIV/AIDS research to date focused more on the quantitative and the medical aspects of HIV/AIDS prevention.

The qualitative research of HIV/AIDS from the socio-cultural perspectives was not adequate in the context of the pastoralist community in Ethiopia. More importantly, most HIV/AIDS studies focussed on the urban areas; the situation of the pastoral community concerning HIV/AIDS research in the context of Ethiopia was overlooked (as discussed in Chapter 1).This study attempted to address, thus, gaps in methodology, knowledge/theories, and study area (geographical) concerning socio-cultural dimension of HIV/AIDS communication.

9.6 FUTURE POSSIBILITIES FOR RESEARCH

The following section presents areas that need further research, which fell outside the scope of this study.

9.6.1 Recommendations for future research

There is a need to include quantitative research and further variables to reach the wider pastoralist community. Other pastoralist communities in Ethiopia such as Afar and Ethio-Somali should be included to have a wider understanding of HIV/AIDS communication in the pastoral areas of Ethiopia from socio-cultural perspectives. The use of a mixed study can also provide the opportunity to fill the gaps of qualitative studies with the strength of a quantitative study, and vice-versa. The use of a quantitative study can also help to generalise the findings so that it could have implications on national HIV/AIDS policy formulation and/or amendments. The cross-sectional case study design alone may not give adequate understanding about the socio-cultural approach to HIV/AIDS communication in the wider pastoralist community. However, this research is a case study based on in-depth analysis into the socio-cultural perspectives of HIV/AIDS communication in the Arero district, Borana.

The researcher believes that there is a need to undertake an ethnographic study regarding the exploration of the socio-cultural appropriateness of HIV/AIDS communication in the pastoralist community of Borana. Spending a year or more in the Borana cultural society, living with the local people, and learning about their way of life can give more information on how to integrate HIV/AIDS communication with the contextual domains so that the communication suits the needs of the target community. The conceptual framework of HIV/AIDS communication adapted from literature and the data should be tested using a multiple qualitative case study research designs to evaluate the effectiveness of the cultural

path of HIV/AIDS communication that focuses the micro aspects of disease prevention: the socio-cultural aspects of HIV/AIDS prevention from the pastoralist perspectives.

Lastly, although it was not the focus area of this study, it is crucial to study HIV/AIDS communication from other perspectives such as the political and economic perspectives of the pastoralist community in Borana, Ethiopia (Tefera & Shewadeg 2022; Tofu et al 2023; Kaba 2019; Rogers et al 2021; Anbacha & Kjosavi 2019; Gebremeskel, Desta & Kassa 2019; Mohamed 2019; Catley 2017). Ethiopian pastoralists are marginalised, both politically and economically. This might have a significant influence on the effectiveness of HIV/AIDS communication as well as fostering adequate health facilities. This area of research in the future would contribute more to the national HIV/AIDS policy regarding addressing the health interests of the marginalised, but significant, population of the Ethiopian pastoralists. In addition, using mixed research design, it is crucial to study the synergy between HIV/ADS communication, uptake of HIV prevention, and HIV viral load in the context of the Borana pastoral community.

9.6.2 Policy recommendations: Ethiopia HIV/AIDS policy

The HIV/AIDS policy of Ethiopia focuses the economic and political aspects to develop societal health (MoH 1999). As a result, the policy landscape was influenced by the donor organisation and western model of HIV/AIDS prevention. The policy documents emphasised the epidemiological aspects of HIV/AIDS prevention, which overlooked the socio-cultural, religious, and gender perspectives (see Chapter 8). In a collectivist and diversified cultural society like Ethiopia, undermining socio-cultural, religious/spiritual, and gender contexts in the national HIV/AIDS policy cannot bring the intended behavioural change in a sustainable manner (Rogers et al 2021; Khandu, Tobgay & McFarland 2021; Adia et al 2019; Serbessa et al 2016; Iwelunmor, Newsome & Airhihenbuwa 2014;Uwah 2013; Airhihenbuwa 2007a).The HIV/AIDS policy of Ethiopia should follow the bottom-up approach of policy formulation that considers the contextual domains in the local areas for effective disease prevention (as discussed in Chapter 8).

The Ethiopian HIV/AIDS policy, as a blueprint, should consider the unique features in the local areas so that health programmes and strategies (including HIV/AIDS strategies) can effectively address the interests of a specific community such as the Borana pastoralists. There is a need to have a pastoralist-friendly policy that properly addresses HIV/AIDS issues in a contextualised way.

9.7 RECOMMENDATIONS FOR THE ARERO DISTRICT, BORANA, OROMIA, ETHIOPIA, HEALTH OFFICE

As discussed in Chapters 6 and 7, HIV/AIDS programmes and communication strategies should consider the mobile pastoralist contexts as well as the harsh climatic conditions and environmental strains in Borana. The health system should pay attention to the positive cultural and religious resources to tackle the problems of the spread of HIV/AIDS. Blaming only the harmful beliefs and practices like *Jaala-Jaaltoo*, polygamy, extramarital sexual relations, widow inheritance, female genital mutilation, early marriage, drug use, alcohol, spiritual healings, holy water, herbal medicine, fortune telling, and the traditional livestock market, should not overshadow the positive socio-cultural and religious resources to curb the spread of HIV/AIDS. Borana cultural institutions such as *Gadaa, Qalluu, Gumii Gaayyoo*, and the social networks like *Buusaa-Gonofaa*, and *Marroo* should be used to address HIV/AIDS messages. Borana cultural leaders, religious fathers, and opinion leaders in the community should participate in HIV/AIDS prevention strategies from the onset of message planning until its execution. The health system should use the positive cultural and religious values, norms, and traditions nearer to the community to tackle the spread of HIV/AIDS among the pastoral community. Incorrect health beliefs and practices that fuel the spread of HIV/AIDS need to be tackled, not only with centrally designed, persuasive, expert-based communication, but also with the more informal, user-friendly, sustainable, community-based conversions led by the cultural and religious leaders (as discussed in Chapters 6and 7) (Jahagirdar et al 2021; Khandu, Tobgay & McFarland 2021; Adia et al 2019; Nweze et al 2018; Rodríguez et al 2017; Serbessa et al 2016).

The health messages delivery system should be property tailored to the Borana oral traditions and values such as fables, proverbs, cultural theatre, cultural songs, cultural symbols, and the artefacts of the pastoral community (as discussed in Chapter 6). Borana oral traditions (oral stories) should be integrated within the HIV/AIDS messages to inculcate moral lessons. The art of communicating HIV/AIDS messages using Borana cultural resources should be emphasised to bring about social behavioural change. The social and behavioural sciences of disease prevention such as societal arts and oral stories that are nearer to the community should be considered for a positive impact. The communication should emphasise the wider contexts of the collectivist cultural group. HIV/AIDS campaign strategies should emphasise the cultural group rather than changing individual behaviours concerning HIV/AIDS.

Borana pastoralist women should have equal rights to their men. Women should be empowered in the social, economic, and political affairs. The health service delivery system and cultural institutions should equally favour men and women, regardless of the sex differences. Women should have sexual rights to protect themselves from HIV/AIDS, free from the cultural and religious imposition. Gender inequality should not expose female pastoralists to harmful practices such as gender-based violence, early marriage, girls' school dropouts, migration, and commercial sex(Damtie et al 2021; Mapingure, Mukandavire & Chinggombe 2021; Khandu, Tobgay & McFarland 2021; Anbacha & Kjosavik 2019a;Serbessa et al 2016;Gebremicheal et al 2018;Girum et al 2018; Kinaroet al 2018; Mtenga et al 2018; Ramjee& Daniel 2013).The direction of HIV/AIDS communication planning should be bottom-up in a more participatory fashion of disease prevention. HIV/AIDS message design and the communication approach (both the content and the means of communication) should engage the target community through properly utilising the local resources that are helpful to combat the spread of HIV/AIDS. The health system should not rely on the already established western behavioural change model of disease prevention and behavioural change theories. Rather, there is a need to look for a culture specific and innovative approach to HIV/AIDS prevention that considers the local contexts (Jahagirdar et al 2021; Audet et al 2019; Nweze et al 2018; Rodríguez et al 2017; Serbessa et al 2016; Iwelunmor, Newsome & Airhihenbuwa 2014; Uwah 2013; Airhihenbuwa 2007a). A culturally driven approach should be favoured over the politically affiliated propaganda model of persuasive communication of HIV/AIDS prevention strategies such as condom use (Peinado et al 2020; Wilson & Taaffe 2017). The deep-rooted practices that exacerbate the spread of HIV/AIDS should be challenged through participatory communication. HIV/AIDS communication among the pastoralist community should adequately address the gender gap in terms of sexual decisions to prevent the spread of HIV/AIDS (see Chapters 6 and 7).HIV/AIDS communication, information, and educational rights of both permanent settlers (highlanders) and the mobile pastoralists (lowlanders) need equal attention. The lowlanders, pastoralists, should have equal access to contextualised HIV/AIDS messages. The communication and the campaign strategy should fit the contextual factors in the pastoralist environments and the pastoralists' lifestyle (see Chapters 6, 7 and 8).

9.8 GENERAL CONCLUSION

The researcher wants to conclude with a quote from Uwah (2013) as well as Somma and Bodiang (2003):

"Culture is one of many factors influencing human behaviour; it is a determinant of socially accepted behaviour, value systems, beliefs, and practical knowledge. Means of expression or communication, such as music, dance, theatre, and art, are those creative aspects of culture. However, culture in the broader sense also includes traditions and local practices, taboos, religious affiliations, gender roles, marriage, and kinship patterns and so forth. Therefore, culture is deeply rooted in all aspects of a society, including local perceptions of health and illness and health-seeking behaviours" (Uwah2013:3; Somma & Bodiang 2003:1).

HIV/AIDS is on the rise again in Ethiopia (Mirkuzie et al 2021; Chapter 2). Ethiopia fully supports the Millennium Development Goal of preventing HIV/AIDS (World Bank 2020). However, the research suggests that the country should do more to address the complex HIV/AIDS issues. The relationship between socio-cultural contexts and HIV/AIDS in Ethiopia is hard to separate (see Chapter 4). We cannot overstate the importance of HIV/AIDS communication in Ethiopia given the epidemics return. In Borana, Ethiopia, socio-cultural, religious, gender, and demographic differences increase the risk of HIV/AIDS. HIV/AIDS communication involves many methods of sharing information between healthcare providers and recipients. In Ethiopia's collectivist culture, HIV/AIDS communication must be socio-cultural. The messaging should match target social contexts in content, medium, and style of communication. To adapt messages to target populations, one must understand their socio-cultural, religious/spiritual, gender, and communication contexts. Effective HIV/AIDS health communication involves adapting messages to target populations.

HIV/AIDS communication in Ethiopia is also impacted by western behavioural change models and ideas, which ignored Ethiopia's collectivist culture. Effective HIV/AIDS communication requires adherence to the target community's circumstances. Unfortunately, Ethiopian HIV/AIDS communication designers have ignored this plea. The greatest Ethiopian pastoralist population is in Borana. Pastoralists in Borana, Oromia, are culturally constrained, impoverished, and marginalised when it comes to health services. Public health research and HIV/AIDS prevention and control in pastoralist Ethiopia are scarce (see Chapters 1 and 2).

As mentioned in Chapters 6 and 7, Borana pastoralists are vulnerable to HIV/AIDS. In addition, as mentioned in Chapter 2, Ethiopians do not value abstinence or faithfulness. This suggests designing pastoralist-friendly HIV/AIDS interventions that consider the local context and culture (Rogers et al 2021; Khandu, Tobgay & McFarland 2021; Seid & Ahmed 2020;

Anbacha & Kjosavik 2019a; Serbessa et al 2016; Kinaro et al 2018; Mtenga et al 2018; Girum et al 2018; Ramjee & Daniel 2013).In this thesis, this cross-sectional case study examined socio-cultural dimensions of HIV/AIDS communication in Borana, Ethiopia's pastoralist community. The project was undertaken because of HIV/AIDS risks and communication gaps among the disadvantaged, marginalised, culturally bound mobile pastoralists in Borana, Ethiopia (World Bank 2020; Rogers et al 2021; Mirkuzie et al 2021; Mtenga et al 2018).

The urgent need to shift from non-contextualised HIV/AIDS communication to culturally embedded and contextualised communication in developing countries like Ethiopia underpinned the study. The cultural appropriateness of HIV/AIDS communication in the Borana pastoralist milieu was explored using in-depth interviews, focus group interviews, and document analysis in this qualitative case study. Data from many sources and lenses revealed and explained multiple aspects of the phenomena. The qualitative case study was suitable to analyse HIV/AIDS communication among the Borana pastoralists from cultural, religious/spiritual, gender, and user-friendly communication perspectives.

Furthermore, HIV/AIDS communication and messaging should empower the local communities through bottom-up disease prevention. Borana pastoralists need a tailored health system and HIV/AIDS programme. The findings and culturally oriented communication framework will aid custom HIV/AIDS communication in the Borana pastoralist community. Ethiopia's HIV/AIDS policy, like economic and political issues, should incorporate the community micro settings to prevent the spread of HIV/AIDS. The pastoralist community in Borana, Ethiopia, should use Afro centric HIV/AIDS prevention and communication strategies like the PEN-3 cultural health model, which emphasises contextual factors to promote positive health behaviour.

In closing, the findings reveal that the Borana pastoralists must consider local settings that prevent HIV/AIDS transmission. HIV/AIDS programmes in the pastoralist community should integrate positive cultural, religious, and spiritual resources while addressing detrimental attitudes and practices that perpetuate the epidemic. Undermining the target community's socio-cultural, religious, and gender components makes HIV/AIDS prevention and social behaviour modification difficult. Gender mainstreaming in the HIV/AIDS programme should address the pastoralist gender dynamics that propagate HIV/AIDS.

LIST OF SOURCES CONSULTED

Aaba, A. 2013. National strategy and action plan on harmful traditional practices (HTPs) against women and children in Ethiopia federal democratic republic of Ethiopia ministry of women (MoWCYA). *Children and Youth Affairs*, pp.1-61.

Abamecha, F., Midaksa, G., Sudhakar, M. 2021. Perceived sustainability of the school-based social and behaviour change communication (SBCC) approach on malaria prevention in rural Ethiopia: stakeholders' perspectives Public Health 21, 1171. https://doi.org/10.1186/s12889-021-11216-7.

Abate, A., Tareke, M., Tirfie, M., Semachew, A., Amare, D.and Ayalew, E., 2018. Chewing khat and risky sexual behaviour among residents of Bahir Dar City administration, Northwest Ethiopia. *Annals of general psychiatry*, 17:26-41.

Abebe, D., Debella, A., Dejene, A., Degefa, A., Abebe, A., Urga, K. and Ketema, L., 2005. Khat chewing habit as possible risk behaviour for HIV infection: A case-control study. *Ethiopian Journal of Health Development*, *19*(3), pp.174-181.

Abdulahi, M., 2005. The changing nature of pastoral conflicts in South-eastern Ethiopia: The case of the Borana and Digodi Pastoralists; Africa peace forum, pastoralist concern association Ethiopia. *Inter-Africa group safer world*, Addis Ababa, Ethiopia.

Abdullahi, M.D., 2001. *Culture and customs of Somalia*. Bloomsbury Publishing USA.

Abduletif, A.A., 2019. Benefits and challenges of pastoralism system in Ethiopia. *Studia Mundi–Economica*, 6(3), pp.5-15.

Abduselam, Mohamed. 2019. Pastoralism and Development Policy in Ethiopia: A Review Study. Budapest International Research and Critics Institute (BIRCI-Journal): Humanities and Social Sciences. 2. 01-11. 10.33258/birci. v2i4.562.

Abrar A, Cheema KJ, Saif S, Mahmood A. 2017. Health status assessment of workers during construction phase of highway rehabilitation projects around lahore, Pakistan. J Occup Health; 59(1):74-80. Doi: 10.1539/joh.16-0123-FS. Epub 2016 Nov 16. PMID: 27853055; PMCID: PMC5388615.

Acharya, D., Devkota, B., Gautam, K. and Bhattarai, R., 2020. Association of information, education, and communication with enrolment in health insurance: a case of Nepal. *Archives of Public Health*, *78*(1), pp.1-13.

Achen, S., Atekyereza, P. and Rwabukwali, C.B., 2021. The role of culture in influencing sexual and reproductive health of pastoral adolescent girls in Karamoja sub-region in Uganda. *Pastoralism, 11*(1), pp.25.

Adegoju, A., 2009. Rhetoric in conflict-related Yoruba proverbs: Guide to constructive conflict resolution in Africa. *African study monographs*, 30(2),pp.55–69.

Adebisi, Y.A., Rabe, A. and Lucero-Prisno III, D.E., 2021. Risk communication and community engagement strategies for COVID-19 in 13 African countries. *Health Promotion Perspectives*, *11*(2), p.137.

Adia, Alexander & Nazareno, Jennifer & Operario, Don & Ponce, N. 2020. Health Conditions, Outcomes, and Service Access among Filipino, Vietnamese, Chinese, Japanese, and Korean Adults in California, 2011–2017. American Journal of Public Health. 110. e1-e7. 10.2105/AJPH.2019.305523.

Adia, A.C., Ng, M.J., Quilantang, M.I., Restar A.J., Hernandez, L.I., Imperial, R.H., Nazareno, J. and Operario, D., 2019. Collective coping strategies for HIV-related challenges among men who have sex with men in Manila, Philippines. *AIDS Education and Prevention*, *31*(5), pp.479-490.

African Union Commission, 2016. Ending child marriage and stopping the spread of HIV: Opportunities and challenges for action.

Agadjanian, V., 2020. Condemned and condoned: Polygynous marriage in Christian Africa. *Journal of Marriage and family*; *82*(2),pp.751-768.

Adal, M.2019. Systematic review on HIV situation in Addis Ababa, Ethiopia. BMC Public Health 19, 1544. https://doi.org/10.1186/s12889-019-7885-8.

Adeodata Kekitiinwa, Mugambi, Melissa Latigo, Sarang Deo, Charles Kiyaga, and Mendel E Singer. 2013. "Do Diagnosis Delays Impact Receipt of Test Results? Evidence from the HIV Early Infant Diagnosis Program in Uganda." PloS one 8, no. 11.

Adesina SK, Akala EO.2015. Nanotechnology Approaches for the Delivery of Exogenous siRNA for HIV Therapy. Mol Pharm; 12(12):4175-87. Doi: 10.1021/acs.molpharmaceut.5b00335. Epub 2015 Nov 9. PMID: 26524196; PMCID: PMC5586487.

Agegnehu, C.D., Geremew, B.M., Sisay, M.M. 2020. Determinants of comprehensive knowledge of HIV/AIDS among reproductive age (15–49 years) women in Ethiopia: further analysis of 2016 Ethiopian demographic and health survey. AIDS Res Ther 17, 51. https://doi.org/10.1186/s12981-020-00305-z.

Agha, S., Hutchinson, P. and Kusanthan, T., 2006. The effects of religious affiliation on sexual initiation and condom use in Zambia. *Journal of Adolescent health*, *38*(5), pp.550-566.

Aghaei, A., Sakhaei, A., Khalilimeybodi, A., Qiao, S., & Li, X. 2023. Impact of Mass Media on HIV/AIDS Stigma Reduction: A Systematic Review and Meta-analysis. AIDS and Behavior, 1-16.

Agot, K.E., Vander Stoep, A., Tracy, M., Obare, B.A., Bukusi, E.A., Ndinya-Achola, J.O., Moses, S. and Weiss, N.S., 2010. Widow inheritance and HIV prevalence in Bondo District, Kenya: baseline results from a prospective cohort study. *PLOS one*, *5*(11), pp.10-23.

Aguilar, MI., 2009. *The politics of God in East Africa: Oromo ritual and religion*. Red Sea Press.

Agustina, R., Ispriantari, A., Konlan, K.D. and Lin, M.F., 2023. Impact of early palliative care on the quality of life in caregivers of cancer patients: A systematic review. *Worldviews on Evidence‐Based Nursing*.

Augustine Bala, N., Azman, A. and Singh, P.S.J., 2022. The impact of gender discrimination and HIV stigma on women living in North Central Nigeria. *Cogent Social Sciences*, *8*(1), p.2027612.

Airhihenbuwa, C.O., 1995. Health and culture: Beyond the Western paradigm.

Airhihenbuwa, C., 2007. On Being Comfortable with being Uncomfortable: Centring an Africanist Vision in Our Gateway to Global Health. SOPHE Presidential Address. *Health Education & Behaviour*, *34* pp.31-42.

Airhihenbuwa, C.O., 2007a. *Healing our differences: The crisis of global health and the politics of identity*. Rowman & Littlefield.

Airhihenbuwa, C.O., 2007b.SOPHE Presidential Address: on being comfortable with being uncomfortable: cantering an Africanist vision in our gateway to global health. *Health Education & Behaviour*, *34*(1), pp.31-42.

Airhihenbuwa, C.O., 2010. Culture matters in global health. *The European Health Psychologist*, *12*(4), pp.50-53.

Airhihenbuwa, C.O. and DeWitt, W.J., 2004. Culture and HIV/AIDS in South Africa. *SAHARA J*, *1*(1), pp.1-13.

Airhihenbuwa, C.O., Ford, C.L., Iwelunmor, J.I., 2014. Why culture matters in health interventions: lessons from HIV/AIDS stigma and NCDs. *Health Education & Behaviour*, *41*(1), pp.78-84.

Airhihenbuwa, C., O., Okoror, T., Shefer, T., Brown, D.,Iwelunmor, J., Smith, E., Adam, M., Simbayi, L., Zungu, N., Dlakulu, R. andShisana, O., 2009. Stigma, culture, and HIV and AIDS in the Western Cape, South Africa: An application of the PEN-3 cultural model for community-based research. *Journal of Black Psychology*, *35*(4), pp.407-432.

Airhihenbuwa, C.O. and Webster, J.D., 2004. Culture and African contexts of HIV/AIDS prevention, care and support. *Sahara-: Journal of Social Aspects of HIV/AIDS, 1*(1) pp.1-13.

Aja, G.N., Modeste, N.N., Lee, J.W., Montgomery, S.B., and Belliard, J.C., 2010. Perceived church-based needs and assets for HIV/AIDS prevention in an urban Nigerian community. *Journal of religion and health*,*49*, pp.50-61.

Akelo V., Girde, S., Borkowf, C.B., Angira, F., Achola, K., Lando, R., Mills, L.A., Thomas, T.K., Lee Lecher, S., 2013. Attitudes toward family planning among HIV-positive pregnant women enrolled in a prevention of mother-to-child transmission study in Kisumu, Kenya*. PLOS one*, *8*(8), p. e66593.

Akkuş, B., Postmes, T., and Stroebe, K., 2017. Community Collectivism: A social dynamic approach to conceptualizing culture. *PLOS One*, *12*(9), p.e0185725.

Akobi, W.K., Oyore, J.P. and Otieno, G.O., 2022. Interventional behavioural change communication on HIV and aids related high risk behaviour among fishermen in Homabay and Siaya Counties, Kenya. *International Journal of Community Medicine and Public Health*, *9*(12), p.4368.

Akuiyibo, S., Anyanti, J., Amoo, B., Aizobu, D.and Idogho, O., 2022. Effects of behaviour change communication on hypertension and diabetes related knowledge, attitude and practices in Imo and Kaduna States: a quasi-experimental study. *BMC Public Health*, *22*(1), pp.715.

Ali, Suadiq S. 2018. Substance abuse in the Ethiopian afar pastoral community." Journal of Addictive Diseases 37.3-4: 245-251.

Alemu, W. G., Zeleke, T. A., & Takele, W. W. 2018. Prevalence and associated factors of khat chewing among students in Ethiopia: a protocol for systematic review and meta-analysis. BMJ open, 8(11), e021157.

Alves, Sabrina & Oliveira, M. 2018. Socio-cultural aspects of health and disease and their pragmatic impact. Journal of Human Growth and Development. 183. 10.7322/jhgd.147236.

Amare, A., Simane, B., Nyangaga, J., Defisa, A., Hamza, D.andGurmessa, B., 2019. Index-based livestock insurance to manage climate risks in Borena zone of southern Oromia, *Ethiopia. Climate Risk Management, 25*, p.100191.

Ambasa-Shisanya, C., 2007. Widowhood in the era of HIV/AIDS: a case study of Slaya District, Kenya. *Sahara-J: Journal of Social Aspects of HIV/AIDS*, *4*(2), pp.606-615.

Amzat, J., Razum, O., 2018. African culture and health. *Towards a sociology of health discourse in Africa*, p.65-77.

Anbacha, A.E., and Kjosavik, D.J., 2019. The dynamics of gender relations under recurrent drought conditions: Astudy of Borana Pastoralists in Southern Ethiopia. *Human Ecology*, *47*, pp.4–5-447.

Anbacha, A.E. and Kjosavik, D.J., 2019. Gendered perspectives of climatic and non-climatic stressors in Borana, southern Ethiopia. *Journal of Arid Environments*,*166*, p.28-36.

Anderson, C., and Kirkpatrick, S., 2016.In-depth interviewing. *International Journal of Clinical Pharmacology*, *38*(3), pp.6314.

Anderson, M., Elam, G., Gerver, S., Solarin, I., Fenton, K., Easterbrook, P., 2008. HIV/AIDS-related stigma and discrimination: Accounts of HIV-positive Caribbean people in the United Kingdom. *Social Science & Medicine*, *67*(5),pp.790-798.

Andrew J. Macnab. 2015. "Children's Oral Health: The Opportunity for Improvement Using the WHO Health Promoting School Model", Advances in Public Health, vol., Article ID 651836, 6 pages, 2015. https://doi.org/10.1155/2015/651836.

Andrew, Prestwick, Webb, TL and Conner, M .2015. Using theory to develop and test interventions to promote changes in health behaviours: Evidence, issues, and recommendations. Current Opinion in Psychology, 5. 1 - 5. ISSN 2352-250X.

Andrews, D.L. and Ritzer, G. 2007. The global in the sporting glocal. Global networks, 7(2), pp.135-153.

Andrulis, D.P. and Brach, C., 2007. Integrating literacy, culture, and language to improve health care quality for diverse populations. *American journal of health behaviour*, *31*(1), pp. S122-S133.

Anugwom, E.E., 2020. Health promotion and its challenges to public health delivery system in Africa. *Public Health in Developing Countries-Challenges and Opportunities*.

Appiah, A. and Gates, H.L. eds., 2010. *Encyclopaedia of Africa* (Vol. 1). Oxford University Press. Arrey, A.E., Bilsen, J., Lacor, P.and Deschepper, R., 2016. Spirituality/religiosity: A cultural and psychological resource among Sub-Saharan African migrant women with HIV/AIDS in Belgium. *PLOS one*, 11(7), p.e0159488.

Asgary, Ramin et al. 2013 "Perceived stigma and discrimination towards people living with HIV and AIDS in Addis Ababa, Ethiopia: a qualitative approach." Journal of Public Health 21: 155-162.

Ashley D. 2006. Understanding Interpersonal Communication Processes Across Health Contexts: Advances in the Last Decade and Challenges for the Next Decade, Journal of Health Communication, 11:1, 93-108, DOI: 10.1080/10810730500461125.

Asresie, M.B., Worku, G.T. and Bekele, Y.A., 2023. HIV Testing Uptake among Ethiopian Rural Men: Evidence from 2016 Ethiopian Demography and Health Survey Data. *HIV/AIDS-Research and Palliative Care*, pp.225-234.

Assefa, Y.and Gilks, C.F., 2020. Ending the epidemic of HIV/AIDS by 2030: Will there be an endgame to HIV, or an endemic HIV requiring an integrated health systems response in many countries? *International Journal of Infectious Diseases*, *100*, pp.273-277.

Attride-Stirling, J., 2001.Thematic networks: an analytic tool for qualitative research. *Qualitative research, 1*(3), pp.385-405,

Aubel, J. and Chibanda, D., 2022. The neglect of culture in global health research and practice. *BMJ Global Health*, *7*(9),p.e009914.

Auerbach, J.D., Parkhurst, J.O. and Cáceres, C.F., 2011. Addressing social drivers of HIV/AIDS for the long-term response: conceptual and methodological considerations. *Global public health, 6*(sup3), pp. S293-S309.

Audet, Carolyn & Burlison, Janeen & Moon, Troy & Sidat, Mohsin & Vergara, Alfredo & Vermund, S2010. Socio-cultural and Epidemiological aspects of HIV/AIDS in Mozambique. BMC international health and human rights. 10. 15. 10.1186/1472-698X-10-15.

Augustine Bala, N., Azman, A. and Singh, P.S.J., 2022. The impact of gender discrimination and HIV stigma on women living in North Central Nigeria. *Cogent Social Sciences*, *8*(1), p.2027612.

Ayele, Wolde Melese, Tesfaye Birhane Tegegne, Yitayish Damite, Muluken Genetu Chane, and Asnakew M.2020. "Consistent Use of Condom and Associated Factors Among Sero-discordant Couples in Northeast Ethiopia, 2020: Qualitative Design Embedded.".

Azia, I., Mukumbang, F.C., Shernaaz, C. andNyembezi, A., 2022. Role of religious beliefs on antiretroviral treatment adherence among Pentecostal Christians in sub-Saharan Africa: a scoping review protocol. *BMJ open*, *12*(4), p.e052750.

Azevedo, M.J. and Azevedo, M.J., 2017. The state of health system(s) in Africa: challenges and opportunities. *Historical perspectives on the state of health and health systems in Africa*, *volume II: the modern era*, pp.1-73..

Babbie, E., 2007. *The practice of social research*.11th Edition, Thompson Wadsworth, Belmont.

Babbie, E.R.and Mouton, J., 2001.*The practice of social research*. South African Edition. Cape Town: Oxford University Press.

Bachelor, G., Brusa, E., Ferretto, D. and Mitschke, A., 2019. Model-based design of complex aeronautical systems through digital twin and thread concepts. *IEEE Systems Journal*, *14*(2), pp.1568-1579.

Badru, O. A., Bain, L. E., & Adeagbo, O. A. 2023. Does adherence to antiretroviral therapy differ by place of residence in Nigeria? A systematic review and meta-analysis protocol. BMJ open, 13(7), e070024.

Bajunirwe, F., Akakimpa, D., Tumwebaze, F.P., Abongomera, G., Mugyenyi, P.N.and Kityo, C.M., 2019. Persistence of traditional and emergence of new structural drivers and factors for the HIV epidemic in rural Uganda; A qualitative study. *PLOS one, 14*(11), p.e0211084.

Balogun, J.A., 2019. Communicating research outcomes sensitively through consistent use of people-first language. *African Journalof Reproductive Health*, *23*(2), pp.9-17.

Bamidele, Olufikayo & Ali, Nasreen & Papadopoulos, Chris & Randhawa, G. 2017. Exploring Factors Contributing to Low Uptake of the NHS Breast Cancer Screening Programme among Black African Women in the UK. Diversity & Equality in Health and Care. 14. 212-219. 10.21767/2049-5471.1000113.

Bandura, A., 1986. Social foundations of thought and action. *Englewood Cliffs*, *NJ*, 1986(23-28).

Bandura, A., 1994. Social cognitive theory and exercise of control over HIV infection. In *Preventing AIDS: Theories and methods of behavioural interventions* (pp.25–59). Boston, MA: Springer US.

Banwell, C., Ulijaszek, S. and Dickson, J. eds., 2013. *When culture impacts health: Global lessons for effective health research.*Acadamic Press.

Baraki, S.G. andThupayagale-Tshweneagae, G.B., 2023. Socio-cultural factors perceived to influence sexual behaviours of adolescents in Ethiopia. *African Journal of Primary Health Care and Family Medicine; 15*(1), p.3865.

Baronawski, T., Perry, C.L.and Parcel, G.S., 2002. How individuals, environments, and health behavior interact.*Health behavior and health education: Theory, research, and practice, 3*, pp.165-184.

Barr, D., Garnett, G.P., Mayer, K.H. and Morrison, M., 2021. Key populations are the future of the African HIV/AIDS pandemic. *Journal of the International AIDS Society*, *24*(Suppl 3).

Bashir, F., Ba Wazir, M., Schumann, B. and Lindvall, K., 2019. The realities of HIV prevention. A closer look at facilitators and challenges faced by HIV prevention programmes in Sudan and Yemen. *Global health action*, *12*(1), p.1659098.

Bassi, M. and Tache, B., 2007. The Borana Conserved Landscape.*Southern Ethiopia: Strengthening Community Conserved AreasLessons, Needs and Recommendations for Policy and practice, Turkey: Kure Mountains*.

Bastien, S., Kajula, L.J.and Muhwezi, W.W., 2011. A review of studies of parent-child communication about sexuality and HIV/AIDS in sub-Saharan Africa. *Reproductive Health*, *8*, pp.1-17.

Basu, Ambar & Dutta, Mohan. 2009. Sex Workers and HIV/AIDS: Analyzing Participatory Culture-Centered Health Communication Strategies. Human Communication Research. 35. 86 - 114. 10.1111/j.1468-2958.2008.01339. x.

Bauer, M., 1996. The narrative interview: Comments on a technique of qualitative data collection London School of Economics and Political Science. Methodology Institute. *Papers in Social Research Methods*.

Baumgartner, L.M., 2012. The Perceived Effect of Time on HIV/AIDS Identity Incorporation. *Qualitative Report*, *17*, p.46.

Baumgartner, L. M.and David, K.N., 2009. Accepting being poz: The incorporation of the HIV identity into the self. *Qualitative Health Research*, *19*(12),pp.1730-1743.

Bedson, J., Skrip, L. A., Pedi, D., Abramowitz, S., Carter, S., Jolloh, M.F., Funk, S., Gobat, N., Giles-Vernick, T., Chowell, G. and de Almeida, J.R., 2021. A review and agenda for integrated disease models including social and behavioural factors. *Nature Human Behaviour*, *5*(7), pp.834-846.

Behnampour, M., Shams, M., Hassanzadeh, R., Ghaffarian Shirazi, H., Naderi, H., & Kariminejad, Z. 2021. Using social marketing to persuade Iranians to donate blood. Health Marketing Quarterly, 1–10. https://doi.org/10.1080/07359683.2021.1940786 [Taylor & Francis Online], [Google Scholar].

Behnke, R., S. Devereux, R. White, M. Wekesa and A. Teshome .2007. The Productive Safety Net Programme in Pastoral Areas: Pilot Design. Addis Ababa.

Bekalu, M.A. and Eggermont, S., 2014. The role of communication inequality in mediating the impacts of socio-ecological and socioeconomic disparities on HIV/AIDS knowledge and risk perception. *International Journal for Equity Health, 13*, pp.1-11.

Bekalu, M.A.Eds. Eggermont, S., 2013. HIV/AIDS-related information needs of urban and rural residents of northwest Ethiopia: alerting the rural populace and meeting the progressive needs of the urban populace. *Information Development*, *29*(4), pp.323-332.

Bekalu, M.A., Eggermont, S. and Viswanath, K.V., 2017. HIV/AIDS communication inequalities and associated cognitive and affective outcomes: A call for a socio-ecological approach to AIDS communication in Sub-Saharan Africa. *Health communication*, *32*(6), pp.685-694.

Belay GM, Yehualashet FA, Ewunetie AW, Atalell KA. 2022. Paediatrics HIV-positive status disclosure and its predictors in Ethiopia: a systematic review and meta-analysis. PeerJ 10:e13896 https://doi.org/10.7717/peerj.13896.

Belay, G. M., Alemu, T. G., Techane, M. A., Wubneh, C. A., Assimamaw, N. T., Tamir, T. T. ... & Atalell, K. A. 2022. COVID-19 vaccine acceptance rate and its predictors in Ethiopia: A systematic review and meta-analysis. Human vaccines & immunotherapeutic, 18(6), 2114699.

Bell, L., & Stevenson, H. 2015. Towards an analysis of the policies that shape public education: Setting the context for school leadership. Management in Education, 29(4), 146-150. https://doi.org/10.1177/0892020614555593.

Belle, J.A. and Gamedze, N.N., 2019. Behavioural factors contributing to the transmission of HIV and AIDS amongst young women of Mbabane in Swaziland. *African health sciences*, *19*(3), pp.2302-2311.

Belus, J.M., Joska, J.A., Bronsteyn, Y., Rose, A.L., Andersen, L.S., Regenauer, K.S., Myers, B., Hahn, J.A., Orrell, C., Safren, S.A. and Magidson, J.F., 2022. Gender Moderates Results of a Randomized Clinical Trial for the Khanya Intervention for Substance Use and ART Adherence in HIV Care in South Africa. *AIDS Behaviours*, *26*(11), pp.3630-3641.

Berhane Y, Mekonnen Y, Seyoum E, Gelmon L, Wilson D.2018. HIV/AIDS in Ethiopia: An Epidemiological Synthesis. Washington DC: World Bank, Global HIV/AIDS program series.

Berhane, Y., Mekonnen, Y., Seyoum, E., Gelmon, L. and Wilson, D., 2008. *HIV/AIDS in Ethiopia: an epidemiological synthesis* (No. 43929, pp. 1-109). The World Bank.

Berkley-Patton, J., Goggin, K., Liston, R., Bradley-Ewing, A. and Neville, S., 2009. Adapting effective narrative-based HIV-prevention interventions to increase minorities' engagement in HIV/AIDS services. *Health Communication*, *24*(3), pp.199-209.

Betancourt, Joseph R., James Corbett, and Matthew R. B. 2014. "Addressing disparities and achieving equity: cultural competence, ethics, and health-care transformation." Chest 145.1: 143-148.

Beverley, Michael & Hughes, J. Carl & Hastings, Richard. 2009. What's the probability of that? Using SAFMEDS to increase undergraduate success with statistical concepts. European Journal of Behaviour Analysis. 10. 235-247.

Bhatta, D.N., Liabsuetrakul, T. and McNeil, E.B., 2017. Social and behavioral interventions for improving quality of life of HIV infected people receiving antiretroviral therapy: a systematic review and meta-analysis. Health and quality of life outcomes, 15, pp.1-14.

Bhattacharya, D., K. Carroll Steward, M. Chandler, and C. F. 2020. Using climate models to learn about global climate change: Investigating the phenomenon of increasing surface air temperatures using a global climate modelling approach. Sci. Teach., 88, no. 1.

Bhattacharya, S., Sekhon, H., Sharma, N.and Singh, A., 2020. Exceptions of diffusion of innovation theory during COVID-19 pandemic and health policy implications. A Viewpoint. *Journal of Surgical Specialties and Rural Practice*, *1*(1), pp.3-7.

Biratu, K. and Kosa, O. 2020. The Roles, Challenges and Opportunities of Gadaa System in Resolving Water Conflict: The Case of Borana Oromo. Open Journal of Social Sciences, 8, 19-31. Doi: 10.4236/jss.2020.82002.

Birhanu, Adamu, and Kadi H. 2016. "Prevalence and factors associated to depression among Ambo university students, Ambo, West Ethiopia." Prevalence 25.

Blevins, J.B., Jalloh, M.F. and Robinson, D.A., 2019. Faith and global health practice in Ebola and HIV Emergencies. *American Journal of Public Health*, *109*(3),pp.379-384.

Blevins, J., 2015. Are Faith-based organizations assets or hindrances for adolescents living with HIV? They Are Both. *Brown Journal of World Affairs*, *22,*pp.25-38.

Bodeker, Gerard & Burford, G2007. Traditional, Complementary and Alternative Medicine: Policy and Public Health Perspectives. 10.1142/9781860949135_0002.

Bogart, L.M. and Delahanty, D.L., 2004. Psychosocial models.

Bose, D.L., Hundal, A., Singh, S., Singh, S., Seth, K., Hadi, S.U., Saran, A., Joseph, J., Goyal, K. and Salve, S., 2023. Evidence and gap map report: Social and Behavior Change Communication (SBCC) interventions for strengthening HIV prevention and research among adolescent girls and young women (AGYW) in low- and middle-income countries (LMICs). *Campbell Systematic Reviews*, *19*(1), p.e1297.

Both, R., Etsub, E. and Moyer, E., 2013. They were about to take out their guns on us: accessing rural Afar communities in Ethiopia with HIV-related interventions. *Culture, health & sexuality*, *15*(sup3), pp.S338-S350.

Bowen, G. A. 2009. Document Analysis as a Qualitative Research Method. Qualitative Research Journal, 9, 27-40.

Braun, V. and Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), pp.77-101.

Bressers, H., 2009. From public administration to policy networks: Contextual interaction analysis. *Rediscovering Public Law, Public Administration Compliance, Policy. Annual Tribute Peter Knoepfel*, pp.123-142.

Broderick, K., Aristide, C., Bullington, B.W., Mwanga-Amumpaire, J., Downs, J.A. and Sundararajan, R., 2023. Stigma of infidelity associated with condom use explains low rates of condom uptake: qualitative data from Uganda and Tanzania. *Reproductive Health*, *20*(1), pp.12.

Brooks, L.A., Manias, E. and Bloomer, M.J., 2019. Culturally sensitive communication in healthcare: A concept analysis. *Collegian*, *26*(3), pp.383-391.

Burke, M., E. Gong, and K. J. 2014. “Income Shocks and HIV in Africa,” Economic Journal.

Burns, P. A., Williams, M. S., Mena, L. A., Bruce, M. A., Bender, M., Burton, E. T., & Beech, B. M. 2020. Leveraging community engagement: the role of community-based organizations in reducing new HIV infections among Black men who have sex with men. Journal of Racial and Ethnic Health Disparities, 7, 193-201.

Bryceson, D.F., 2019. Gender and generational patterns of African deagrarianization: Evolving labour and land Allocation in smallholder peasant household farming, 1980-2015. *World development*, *113*, pp.60-72.

Bunn, C., Kalinga, C., Mtema, O., Abdulla, S., Dillip, A., Lwanda, J.,Mtenga, S.M., Sharp, J., Strachan, Z. and Gray, C.M., 2020. Arts-based approaches to promoting health in sub-Saharan Africa: a scoping review. *BMJ Global Health*, *5*(5),p.e001987.

Burger, M., 2015. A future direction for HIV/AIDS communication: participation, HIV-positive celebrities and their public self-expression. *Communities, 20,* pp.200-217.

Burger, M., 2015. Talk radio as the soundtrack of our lives: participatory HIV/AIDS communication, public self-expression and positive talk. *SAHARA: Journal of Social Aspects of HIV/AIDS Research Alliance*, *12*(1), pp.66-75.

Burgess, R.A., Shittu, F., Iuliano, A., Haruna, I., Valentine, P., Bakare, A.A., Colbourn, T., Graham, H.R., McCollum, E.D., Falade, A.G. and King, C., 2023. Whose knowledge counts? Involving communities in intervention and trial design using community conversations. *Trials*, *24*(1), pp.385.

Buseh, A.G., Glass, L.K.and McElmurry, B.J., 2002. Cultural and gender issues related to HIV/AIDS prevention in rural Swaziland: a focus group analysis. *Health Care for Women International*, *23*(2),pp.173-184.

Butler, M., McCreedy. E., Schwer, N., Burgess, D., Call, K., Przedworski, J., Rosser, S., Larson, S., Allen, M., Fu,S. and Kane, R.L., 2016. Improving cultural competence to reduce health disparities.

Cain, D., Pitpitan, E.V., Eaton, L., Carey, K.B., Carey, M.P., Mehlomakulu, V., Harel, O., Simbayi, L.C., Mwaba, K. and Kalichman, S.C., 2013. Collective Efficacy and HIV Prevention in South African Townships. *Journal of community health*, *38*, pp.885-893.

Calton, J. M., Heesacker, M., & Perrin, P. B. 2014. The elusiveness of progressive masculinity: Gender differences in conceptualizations of non-traditional gender roles.

Camlin, C.S. and Charlebois, E.D., 2019. Mobility and its effects on HIV acquisition and treatment engagement: recent theoretical and empirical advances. *Current HIV/AIDS Reports*, *16* pp.314-323.

Campbell, C., Nhamo, M., Scott, K., Madanhire, C., Nyamukapa, C., Skovdal, M. and Gregson, S., 2013. The role of community conversations in facilitating local HIV competence: case study from rural Zimbabwe*. BMC public health, 13*(1), pp.1-15.

Campbell, C., Nair, Y., Maimane, S., Sibiya, Z.and Gibbs, A., 2012. Dissemination as Intervention: building local HIV competence through the report back of research findings to a South African rural community. *Antipode, 44*(3),pp.702-724.

Carrington, D. 2019. Why the Guardian is changing the language it uses about the environment. The Guardian, 17.

Carrington, K., Dixon, B., Fonseca, D., Goyes, D. R., Liu, J., & Zysman, D. 2019. Criminologies of the global south: Critical reflections. Critical Criminology, 27, 163-189.

Cassels S, Goodreau SM. 2011. Interaction of mathematical modelling and social and behavioural HIV/AIDS research. Curr Opin HIV AIDS; 6(2):119-23. Doi: 10.1097/COH.0b013e328343acad. PMID: 21505386; PMCID: PMC3091501.

Catley, A., 2017. Pathways to Resilience in Pastoralist Areas. *AFeinstein International Center Brief*.

Catley, A., Lind, J. and Scoones, I., 2013. Development At The Margins. *Pastoralism and Development in Africa*, p.1.

Central Statistical Agency. 2013. *Population projection of Ethiopia for all regions at Woreda level from 2014–2017*. Addis Ababa.

Chala, D.G. and Haro, J.D., 2023. Virginity as a sign of Masculinity: The case of the Borana Oromo, Ethiopia. *Cogent Social Sciences*, *9*(1), p.2194739.

Chandler, R., Ross, H., & Guillaume, D. 2022. Innovative perception analysis of HIV prevention messaging for black women in college: a proof of concept study. BMC Public Health, 22(1), 1255.

Chetty-Makkan, C.M., Grund, J.M., Muchiri, E., Price, M.A., Latka, M.H. and Charalambous, S., 2021. High risk sexual behaviours associated with traditional beliefs about gender roles among men interested in medical male circumcision in South Africa. *AIDS Research and Therapy, 18*(1), pp.33.

Chinsembu, K.C., Syakalima, M. and Semenya, S.S., 2019. Ethno medicinal plants used by traditional healers in the management of HIV/AIDS opportunistic diseases in Lusaka, Zambia. *South African Journal of Botany*, *122*, pp.369-384.

Choi, Y.and Suh, K.H., 2022. Verifying the usefulness of the theory of planned behavior model for predicting illegal use of online content: the role of outcome expectancies and social loafing. *BMC Psychology 10*(1), pp.263.

Choudhry V, Ambresin AE, Nyakato VN, Agardh A. 2015. Transactional sex and HIV risks - evidence from a cross-sectional national survey among young people in Uganda. Glob Health Action; 8:27249. Doi: 10.3402/gha.v8.27249. PMID: 26001780; PMCID: PMC4441731.

Chory, A., Gillette, E., Callen, G., Wachira, J., Sam-Agudu, N.A., Bond, K., Vreeman, R., 2023. Gender differences in HIV knowledge among adolescents and young people in low-and middle-income countries: a systematic review. *Frontiers in Reproductive Health, 5*.

Church, K., Kiweewa F., Dasgupta, A., Mwangome, M., Mpandaguta, E., Gómez-Olivé, F.X., Oti, S., Todd, J., Wringe, A., Geubbels, E. andCrampin, A., 2015. A comparative analysis of national HIV policies in six African countries with generalized epidemics. *Bulletin of the World Health Organization*, *93*(7), pp.457-67.

Claramita, M., Tuah, R., Riskione, P., Prabandari, Y.S. and Effendy, C. 2016. Comparison of communication skills between trained and untrained students using a culturally sensitive nurse–client communication guideline in Indonesia. *Nurse Education Today, 36*, pp. 236-241.

Closson, K., Dietrich, J.J., Lachowsky, N.J., Nkala, B., Palmer, A., Cui, Z., Beksinska, M., Smit, J.A., Hogg, R.S., Gray, G. and Miller, C.L., 2018. Sexual self-efficacy and gender: A review of condom use and sexual negotiation among young men and women in Sub-Saharan Africa. *The Journal of Sex Research*, *55*(4-5), pp.522-539.

Cogburn, C.D., 2019. Culture, race, and health: implications for racial inequities and population health. *The Milbank Quarterly; 97*(3), pp.736-761.

Cohen, D.A.and Farley, T.A., 2004. Social marketing of condoms is great, but we need more free condoms. *The Lancet, 364*(9428), pp.13-14.

Colvin, M. and Sharp, B., 2000. Sexually transmitted infections and HIV in a rural community in the Lesotho highlands. *Sexually Transmitted Infections*, *76*(1), pp.39-42.

Cook, C.E., Bailliard, A., Bent, J.A., Bialosky, J.E., Carlino, E., Colloca, L., Esteves, J.E., Newell, D., Palese, A., Reed, W.R. and Vilardaga, J.P., 2023. An international consensus definition for contextual factors: findings from a nominal group technique. *Frontiers in Psychology, 14*.

Cook, J.A., Burke-Miller, J.K., Steigman, P.J., Schwartz, R.M., Hessol, N.A., Milam, J., Merenstein, D.J., Anastos, K., Golub, E.T. and Cohen, M.H., 2018. Prevalence, comorbidity, and correlates of psychiatric and substance use disorders and

associations with HIV risk behaviours in a multisite cohort of women living with HIV. *AIDS and Behaviour*, *22*, pp.3141-3154.

Coppock, D. Layne, and Solomon D. 2013.Collective action, innovation, and wealth generation among settled pastoral women in northern Kenya." Rangeland Ecology & Management 66.1: 95-105.

Coppock, D., L.1994. The Borana Plateau of Southern Ethiopia: Synthesis of Pastoral Research, Development, and Change, 1980- 1991. System Study No. 5. International Livestock Center for Africa, Addis Ababa, Ethiopia.

Corbin, J. and Strauss, A., 2008. Basics of qualitative research: *Techniques and procedures for developing grounded theory (3rd ed.).* Thousand Oaks, CA: Sage.

Corcoran, N., 2007. Theories and models in communicating health messages. Communicating health: *Strategies for health promotion*, pp.5-31.

Cornell, M., Majola, M., Johnson, L.F., Dubula-Majola, V., 2021. HIV services in sub-Saharan Africa: the greatest gap is men. *The Lancet, 397*(10290), pp.2130-2132.

Cornish, F., Priego-Hernandez, J., Campbell, C., Mburu, G., & McLean, S. 2014. The impact of community mobilisation on HIV prevention in middle- and low-income countries: a systematic review and critique. AIDS and Behaviour, 18, 2110-2134.

Cowdery, J.E., Parker, S. and Thompson, A., 2010. Application of the PEN-3 model in a diabetes prevention intervention. *Journal of Health Disparities Research and Practice*, *4*(1), p.3.

Creswell, J.W. and Creswell, J.D., 2017. *Research design: Qualitative, quantitative, and mixed method approaches*. Sage publications. Crocker, A.F.and Smith, S.N., 2019. Person-first language: are we practicing what we preach? *Journal of multidisciplinary Healthcare*, p.125-129.

Crosby, R.A. and DiClemente, R.J. eds., 2018. *Structural interventions for HIV Prevention*: *Optimizing strategies for reducing new infections and improving care*, Oxford University Press.

CSA .2013. *Population Projection of Ethiopia for All Regions at Woreda Level from 2014 – 2017*, Central Statistical Agency, Addis Ababa, https://www.scribd.com/document/343869975/Population-Projection-At-Wereda-Level-from-2014-2017-pdf.

Cuevas, A.G., O'Brien, K. and Saha, S., 2017. What is the key to culturally competent care: Reducing bias or cultural tailoring? *Psychology & health*, *32*(4), pp.493-507.

Dadipoor, S., Alavi, A., Kader, Z., Mohseni, S. Eshaghi Sani Kakhaki, H. and Shahabi, N., 2023. Predictive power of PEN-3 cultural model in cervical cancer screening among women: a cross-sectional study in South of Iran. *BMC Cancer 23*(1), pp.1-12.

Damtie, Y., Kefale, B., Yalew, M., Arefaynie, M. and Adane, B., 2021. Multilevel analysis of determinants of polygyny among married men in Ethiopia. *BMC Public Health*, *21*, p.1-10.

Dastmanesh, S., Karimi, M., Ghahremani, L., Seif, M. and Zare, E., 2023. A health communication campaign for prevention of osteoporosis in rural elderly women. *BMC Women's Health 23*(1), p.124.

Davidson, C., 2009. Transcription: Imperatives for qualitative research. *International journal of qualitative methods*, *8*(2), pp.35-52.

Davis, R., Campbell, R., Hildon, Z., Hobbs, L. and Michie, S., 2015. Theories of behaviour and behaviour change across the social and behavioural sciences: a scoping review. *Health Psychology Review*, *9*(3), pp.323-44.

Declaration, J., 1997. Jakarta declaration on leading health promotion into the 21st century. In *Fourth International Conference on Health Promotion, Jakarta*.

De Graca, F.L.B., 2002. HIV/AIDS prevention and care in Mozambique. A socio-cultural approach.

Delgadillo, J.D., Campbell, L.M., Marquine, M.J., Heaton, A., Rooney, A.S., Umlauf, A., Jeste, D.V., Moore, D.J. and Moore, R.C., 2022. Higher religiosity and spirituality are associated with ethnic group membership among middle-aged and older adults living with HIV. *HIV research & clinical practice*, *23*(1), pp.91-98.

De Morais Pinto, R., De Medeiros Valentim, R.A., Fernandes da Silva, L., Góis Farias de Moura Santos Lima, T., Kumar, V., Pereira de Oliveira, C.A., Martins Gomes de Gusmão, C., de Paiva, J.C. and de Andrade, I., 2021. Analyzing the reach of public health campaigns based on multidimensional aspects: the case of the syphilis epidemic in Brazil. *BMC Public Health*, *21*, pp.1-13.

Denzin, N. K., & Lincoln, Y. S. 2011. The SAGE Handbook of Qualitative Research. Thousand Oaks, CA: Sage.

Denzin, N.K.,& Lincoln, Y., 2003. Collecting and interpreting qualitative materials. Thousand Oaks: Sage.

Denzin, N. K., & Lincoln, Y. S. 1998. The landscape of qualitative research: Theories and issue. London: Sage Publications.

De Oliveira Valente, T.C., da Silva, L.M. and Cavalcanti, A.P.R., 2022. Spiritual Needs as Expressed by People Living with HIV. A Systematic Review*. Religions,* 13(4), p.342.

Deribew, A., Biadgilign, S., Deribe, K., Dejene, T., Tessema, G.A., Melaku, Y.A., Lakew, Y., Amare, A.T., Bekele, T., Abera, S.F. and Desalegn, M., 2019. The burden of HIV/AIDS in Ethiopia from 1990 to 2016: evidence from the global burden of diseases 2016 study. *Ethiopian journal of health sciences*, *29*(1).

Devon, K., Baggett, C. D., Kim, K., & Roberts, A. W. 2021. Predictors of Chronic Opioid Use: A Population-Level Analysis of North Carolina Cancer Survivors Using Multi-Payer Claims.

Dilger, H., Burchardt, M., & van Dijk, R. 2010. Introduction—The redemptive moment: HIV treatments and the production of new religious spaces. African journal of AIDS research, 9(4), 373-383.

Douglas, M.K., Rosenkoetter, M., Pacquiao, D.F., Callister, L.C., Hattar-Pollara, M., Lauderdale, J., Milstead, J., Nardi, D. and Purnell, L., 2014. Guidelines for implementing culturally competent nursing care. *Journal of Transcultural Nursing, 25*(2), pp109-21.

Douglas, M.K., Pierce, J.U., Rosenkoetter, M., Pacquiao, D., Callister, L.C.,Hattar-Pollara, M.,Lauderdale, J., Milstead, J., Nardi, D. and Purnell, L., 2011. Standards of practice for culturally competent nursing care: 2011 update. *Journal of Transcultural Nursing*, *22*(4), pp317-333.

Douglas, N.M., Pontororing, G.J., Lampah, D.A., Yeo. T.W., Kenangalem, E., Poespoprodjo, J.R., Ralph, A.P., Bangs, M.J., Sugiarto, P., Anstey, N.M. and Price, R.N., 2014. Mortality attributable to Plasmodium vivax malaria: a clinical audit from Papua, Indonesia. *BMC Medicine*, 12(1), pp1-13.

Dubé, K., Peterson, B., Jones, N.L., Onorato, A., Carter, W.B., Dannaway, C., Johnson, S., Hayes, R., Hill, M., Maddox,R. and Riley, J.L. 2023. Community engagement group model in basic and biomedical research: lessons learned from the BEAT-HIV Delaney Collaborator towards an HIV-1 cure. *Research Involvement and Engagement*, *9*(1), pp.1-17.

Dubé,K.,Auerbach, J.D., Stirratt, M.J. and Gaist, P., 2019. Applying the behavioural and social sciences research (BSSR) functional framework to HIV cure research. *Journal of the International AIDS Society, 22*(10),p.e25404.

Du Plooy, G.T. and Du Plooy, G.M., 2009. *Communication research: Techniques, methods and applications.* Juta and Company Ltd.

Dugassa, B.F., 2014. Reclaiming Oromo Indigenous Organizational Structures and Fostering Supportive Environments for Health*. Archives of Business Research*, *2*(1), pp.23-45.

Dugassa, B.F., 2006. Ethiopian language policy and health promotion in Oromia. *Journal of Sociology & Social Welfare*, 33, p.69.

Durosinmi-Etti, O., Nwala, E.K., Oki, F., Ikpeazu, A., Godwin, E., Umoh, P., Shaibu, A., Ogundipe, A. and Kalaiwo, A., 2021. Communication needs for improved uptake of PrEP and HIVST services among key populations in Nigeria: a mixed-method study. *AIDS Research and Therapy*,*18*, pp.1-13.

Dutta, M.J., 2007. Communicating about culture and health: Theorizing culture-centered and cultural sensitivity approaches. *Communication Theory*,*17*(3), pp.304-328.

Dutta-Bergman, M. 2006. Media Use Theory and Internet Use for Health Care. In Murero, M. and Rice, E., Eds., The Internet and Health Care: Theory, Research and Practice, Lawrence Erlbaum, Mahwah, 83-103.

Dworkin, S.L., Kambou, S.D., Sutherland, C., Moalla, K. and Kapoor, A., 2009. Gendered empowerment and HIV prevention: policy and programmatic pathways to success in the MENA region. *Journal of acquired immune deficiency syndromes (1999)*, *51*(Suppl 3), p.S111.

Dwyer, R., Davis, I. and Emerald, E. eds., 2017.*Narrative research in practice: Stories from the field*. Singapore: Springer Singapore.

Dzimiri, C.T., Dzimiri, P. and Batisai, K., 2019. Fighting against HIV and AIDS within a resource constrained rural setting: a case study of the Ruvheneko Programme in Chirumhanzu, Zimbabwe.*SAHARA-J: Journal of Social Aspects of HIV/AIDS*,*16*(1), pp.25-34.

Dzomba, A., Kim, H.Y., Tomita, A., Vandormael, A., Govender, K. and Tanser, F., 2022. Predictors of migration in an HIV hyper-endemic rural South African community: evidence from a population-based cohort (2005–2017). *BMC Public Health*, *22*(1), pp.1-11.

Eaton, J.W., Hallett, T.B. and Garnett, G.P., 2011. Concurrent sexual partnerships and primary HIV infection: a critical interaction. *AIDS and Behavior*,*15*, pp.687-692.

Edgar, T., Noar, S.M. and Freimuth, V.S. eds., 2009. *Communication perspectives on HIV/AIDS for the 21st century*. Routledge.

Edossa, D. C. & Babel, M. S. & Das Gupta, A. & Awulachew, Seleshi B. 2005. "Indigenous systems of conflict resolution in Oromia, Ethiopia," IWMI Books, Reports H038765, International Water Management Institute.

Edwards, J.K., Arimi, P., Ssengooba, F., Mulholland, G., Markiewicz, M., Bukusi, E.A., Orikiiriza, J.T., Virkud, A. and Weir, S., 2019. The HIV care continuum among resident and non-resident populations found in venues in East Africa cross-border areas.*Journal of the International AIDS Society*,*22*(1), p.e25226.

Edwards, N. and Barker, P.M., 2014. The importance of context in implementation research.*JAIDS Journal of Acquired Immune Deficiency Syndromes*,*67*, pp.S157-S162.

Eisenhardt, K.M., 1989. Building theories from case study research.*Academy of management review*,*14*(4), pp.532-550.

Elrod, J.K. and Fortenberry, J.L., 2018. Catalyzing marketing innovation and competitive advantage in the healthcare industry: the value of thinking like an outsider.*BMC health services research*, *18*, pp.45-48.

Elias, E. 2016. Characteristics of Nitisol profiles as affected by land use type and slope class in some Ethiopian highlands. Environ Syst Res 6. https://doi.org/10.1186/s40068-017-0097-2.

Embleton, L., Logie, C.H., Ngure, K., Nelson, L., Kimbo, L., Ayuku, D., Turan, J.M. and Braitstein, P., 2023. Intersectional stigma and implementation of HIV Prevention and Treatment Services for adolescents living with and at risk for HIV: Opportunities for Improvement in the HIV Continuum in Sub-Saharan Africa. *AIDS and Behavior*, *27*(Suppl 1), pp.162-184.

Emmons, R.A., 2003. *The psychology of ultimate concerns: Motivation and spirituality in personality*. Guilford Press.Endale Gurmu, A., Teni, F.S. and Tadesse, W.T., 2017. Pattern of traditional medicine utilization among HIV/AIDS patients on antiretroviral therapy at a university hospital in north-western Ethiopia: a cross-sectional study. *Evidence-Based Complementary and Alternative Medicine*, *2017*.

Endalamaw, A., Mekonnen, M., Geremew, D., Yehualashet, F.A., Tesera, H. and Habtewold, T.D., 2020. HIV/AIDS treatment failure and associated factors in Ethiopia: meta-analysis. *BMC Public Health*,*20*(1), pp.1-12.

Erman A, Medeiros M.2021. Exploring the Effect of Collective Cultural Attributes on Covid-19-Related Public Health Outcomes. Front Psychol.; 12:627669. Doi: 10.3389/fpsyg.2021.627669. PMID: 33833717; PMCID: PMC8021731.

Ethiopia. An Epidemiological Synthesis: Annual report: In press, Addis Ababa.

Ethiopian Herald Newspaper (EHNP).2017. *HIV/AIDS Report*, Addis Ababa, Ethiopia.

Ethiopia National Strategic Framework for Paediatrics HIV/AIDS Communication. 2010.

Ethiopian Public Health Institute. 2023. HIV Related Estimates and Projections in Ethiopia, Addis Ababa, Ethiopia.

Ethiopia, S.S., 2008. Pastoralism in Ethiopia: Its total economic values and development challenges. *For IUCN-WISP, Nairobi*.

Evans, Doug & Kadirov, Kuyosh & Thior, Ibou & Ganesan, Ramakrishnan & Ulasevich, Alec & Deperthes, B. 2018. Willingness to Pay for Condoms among Men in Sub-Saharan

Africa. International journal of environmental research and public health. 16. 10.3390/ijerph16010034.

FAO (Food and Agriculture Organization). 2018. Livestock production systems spotlight cattle sectors in Ethiopia. Africa Sustainable Livestock, 2050. © FAO, I8271EN/1/01.18.

Fauci, A.S. and Lane, H.C., 2020. Four decades of HIV/AIDS—much accomplished much to do. *New England Journal of Medicine*,*383*(1), pp.1-4.

Federal HIV/AIDS Prevention and Control Office (FHAPCO) .2021-2025. HIV/AIDS National strategic Plan for Ethiopia.

Federal HIV/AIDS Prevention and Control Office, 2014. *HIV/AIDS Strategic Plan 2015-2020 in an Investment Case Approach*.

Federal HIV/AIDS Prevention and Control Office, 2014. *HIV/AIDS in Ethiopia.*

Federal HIV/AIDS Prevention and Control Office (FHAPCO). 2011. Country Progress Report on HIV/AIDS. Addis Ababa: FMOH.

Federal HIV/AIDS Prevention and Control Office, 2010. Report on progress towards implementation of the UN declaration of commitment on HIV/AIDS. *Federal Democratic Republic of Ethiopia*. Federal HIV/AIDS Prevention and Control Office, 2018.*HIV/AIDS in Ethiopia. An Epidemiological Synthesis*. Federal HIV/AIDS Prevention and Control Office, 2018. *HIV Prevention in Ethiopia National Road Map 2018-2020*.

Federal HIV/AIDS Prevention and Control Office (FHAPCO). 2007. HIV / AIDS IN ETHIOPIA - AN EPIDEMIOLOGICAL SYNTHESIS. FMOH.

Fentie, E.A., Kidie, A.A., Fetene, S.M. and Shewarega, E.S., 2023. Socioeconomic inequality in early sexual initiation among female youths in sub-Saharan African countries: a decomposition analysis *Public Health*,*23*(1), p.1283.

Federal Ministry of Health of Ethiopia (FMOH). 2015. Health Sector Transformation Plan. Addis Ababa: FMOH.

Feresu, S. and Smith, L., 2013. Knowledge, attitudes, and beliefs about HIV/AIDS of Sudanese and Bantu Somali immigrant women living in Omaha, Nebraska. *Open Journal of Preventive Medicine*, *3*(01), pp.84-98. Feyasa, M.B., Gebre, M.N. and Dadi, T.K., 2022. Levels of HIV/AIDS stigma and associated factors among sexually active Ethiopians: analysis of 2016 Ethiopian Demographic and Health Survey Data. *BMC Public Health*, *22*(1), pp.1-11.

Fleming, P. J., Colvin, C., Peacock, D., & Dworkin, S. L. 2016. What role can gender-transformative programming for men play in increasing men's HIV testing and engagement in HIV care and treatment in South Africa. Culture, health & sexuality, 18(11), 1251-1264.

Flick, U. 2015. Qualitative Inquiry? Developments, Trends, and Challenges for the Politics of Research. Qualitative Inquiry, 21(7), 599-608. https://doi.org/10.1177/1077800415583296.

Firestone, R., Rowe, C.J., Modi, S.N. and Sievers, D., 2017. The effectiveness of social marketing in global health: a systematic review. *Health policy and planning*, *32*(1), pp.110-124.

Fishbein, M. and Yzer, M.C., 2003. Using theory to design effective health behaviour interventions. *Communication theory*,*13*(2), pp.164-183.

Fishbein, Martin, and Mary G. 1996 "Behavioural science and public health: a necessary partnership for HIV prevention." Public Health Reports 111.Suppl 1: 5.

Flint, A., 2015. Traditional healing, biomedicine and the treatment of HIV/AIDS: contrasting South African and native American experiences. *International journal of environmental research and public health*, *12*(4), pp.4321-4339.

Foege, W.H., 2010. Social determinants of health and healthcare solutions. *Public Health Reports*, *125*(4_suppl), pp.8-10.

Ford, N., Williams, A., Renshaw, M. and Nkum, J., 2005. Communication strategy for implementing community IMCI. *Journal of health communication*, *10*(5), pp.379-401.

Foust, J.L. and Taber, J.M., 2023. Injunctive social norms and perceived message tailoring are associated with health information seeking. *Journal of Behavioural Medicine*, pp.1-14.

Fowler, M. and Peterson, B.S., 1997. Spiritual themes in clinical pastoral education. *Journal of Supervision and Training in Ministry*,*18*, pp.46-54.

Freeman D, Dunn G, Startup H, Pugh K, Cordwell J, Mander H, Černis E, Wingham G, Shirvell K, Kingdon D.2012 Effects of cognitive behaviour therapy for worry on persecutory delusions in patients with psychosis (WIT): a parallel, single-blind, randomised controlled trial with a mediation analysis. Lancet Psychiatry; 2(4):305-13. Doi: 10.1016/S2215-0366(15)00039-5. Epub 2015 Mar 31. PMID: 26360083; PMCID: PMC4698664.

Freudenberg, N., 2000. Health and culture: Beyond the western paradigm.

Futures Group International-Ethiopia. 2000a. *Community and Personal Perception of Risk and Vulnerability to HIV Infection and AIDS*. Report prepared by United Management Consultants for the Futures Group International-Ethiopia. Addis Ababa, September.

Foster, C., Eisenberg, D. M., Kessler, R. C., Norlock, F. E., Calkins, D. R., & Delbanco, T. L. 1993. Unconventional medicine in the United States--prevalence, costs, and patterns of use. New England journal of medicine, 328(4), 246-252.

Gakunga, N.J., Mugisha, K., Owiny, D. and Waako, P., 2014. Effects of crude aqueous leaf extracts of Citropsis articulata and Mystroxylonaethiopicum on sex hormone levels in male albino rats. *International Journal of Pharmaceutical Science Invention*,*3*(1), pp.5-17.

Gamarel, K.E., King, W.M. and Operario, D., 2022. Behavioural and social interventions to promote optimal HIV prevention and care continua outcomes in the United States. *Current Opinion in HIV and AIDS*,*17*(2), p.65.

Gammino, V.M., Diaz, M.R., Pallas, S.W., Greenleaf, A.R. and Kurnit, M.R., 2020. Health services uptake among nomadic pastoralist populations in Africa: a systematic review of the literature. *PLOS One neglected tropical diseases*,*14*(7), p.e0008474.

Gardner, E.M., McLees, M.P., Steiner, J.F., Del Rio, C. and Burman, W.J., 2011. The spectrum of engagement in HIV care and its relevance to test-and-treat strategies for prevention of HIV infection. *Clinical infectious diseases*,*52*(6), pp.793-800.

Gari, S., Doig-Acuña, C., Smail, T., Malungo, J.R., Martin-Hilber, A. and Merten, S., 2013. Access to HIV/AIDS care: a systematic review of socio-cultural determinants in low- and high-incomecountries *health services research*,*13*(1), pp.1-13.

Garrison-Desany, Henri & Wilson, Emily & Munos, Melinda & Sawadogo-Lewis, Talata & Maïga, Abdoulaye & Ako, Onome & Mkuwa, Serafina & Hobbs, Amy & Morgan, Rosemary. 2021. The role of gender power relations on women's health outcomes: evidence from a maternal health coverage survey in Simiyu region, Tanzania. BMC Public Health. 21. 909. 10.1186/s12889-021-10972-w.

Gazimbi, M.M., Magadi, M.A., Onyango-Ouma, W., Walker, E., Cresswell, R.B., Kaseje, M. and Wafula, C.O., 2020. Is polygyny a risk factor in the transmission of HIV in sub-Saharan Africa? A systematic review. *African Journal of Reproductive Health*, *24*(4), pp.198-212.

Gebeyehu, N.A., Chanko, K.P. and Yesigat, Y.M., 2020. Factors associated with condom use self-efficacy among preparatory school students in Sodo Town, Southern Ethiopia 2020: a cross-sectional study. *HIV/AIDS-Research and Palliative Care*, pp.363-371.

Gebremeskel, E.N., Desta, S. and Kassa, G.K., 2019. Pastoral Development in Ethiopia: Trends and the way forward.

Gebremicheal, K., Alemseged, F., Ewunetu, H., Tolossa, D., Ma'alin, A., Yewondwessen, M. and Melaku, S., 2018. Sequela of female genital mutilation on birth outcomes in Jijiga

town, Ethiopian Somali region: a prospective cohort study.*BMC pregnancy and childbirth*,*18*(1), pp.1-10.

Gelibo, T., Lulseged, S., Eshetu, F., Abdella, S., Melaku, Z., Ajiboye, S., Demissie, M., Solmo, C., Ahmed, J., Getaneh, Y. and Kaydos-Daniels, S.C., 2022. Spatial distribution and determinants of HIV prevalence among adults in urban Ethiopia: Findings from the Ethiopia Population-based HIV Impact Assessment Survey (2017–2018). *PLOSOne*,*7*(7), p.e0271221.

Genrich, G.L. and Brathwaite, B.A., 2005. Response of religious groups to HIV/AIDS as a sexually transmitted infection in Trinidad. *BMC public health*, *5*, pp.1-12.

Gesler, W.M., 1984. Healthcare in developing countries. Washington, DC: Association of American Geographers.

Gesesew, H.A., Ward, P., Woldemichael, K. and Mwanri, L., 2020. HIV care continuum outcomes: can Ethiopia meet the UNAIDS 90-90-90 targets? *Ethiopian journal of health sciences*, *30*(2).

Gichuru, E., Kombo, B., Mumba, N., Sariola, S., Sanders, E.J. and van der Elst, E.M., 2018. Engaging religious leaders to support HIV prevention and care for gays, bisexual men, and other men who have sex with men in coastal Kenya.*Critical public health*,*28*(3), pp.294-305.

Girum, T., Wasie, A., Lentiro, K., Muktar, E., Shumbej, T., Difer, M., Shegaze, M. and Worku, A., 2018. Gender disparity in epidemiological trend of HIV/AIDS infection and treatment in Ethiopia.*Archives of Public Health*,*76*, pp.1-10.

Girum, T., Wasie, A. and Worku, A., 2018. Trend of HIV/AIDS for the last 26 years and predicting achievement of the 90–90-90 HIV prevention targets by 2020 in Ethiopia: a time series analysis. *BMC infectious diseases*,*18*(1), pp.1-10.

Glanz, K., Rimer, B.K. and Viswanath, K. eds., 2015. *Health behavior: Theory, research, and practice*. John Wiley & Sons.

G k, R., & Glanz, K. 2005. Theory at a glance: a guide for health promotion practice (Second edition).

Global Health Policy. 2023. The Global HIV/AIDS Epidemic.

Global Fund. 2018. Ethiopia: Disbursements by Component.

GodifeyWubneh, K., Mulaw Desta, F. and Amsalu Kahsay, H., 2021. Mathematical modeling and analysis of khat-chewing dynamics. *Journal of Mathematics*, *2021*, pp.1-12.

Golo, B.W.K. and Novieto, E., 2022. Religion and Sustainable Development in Africa: Neo-Pentecostal Economies in Perspective. *Religion and Development*, *1*(1), pp.73-95.

Goodwin, M.H., 2015. A care-full look at language, gender, and embodied intimacy. *Shifting Visions: International Gender and Language Research (Newcastle: Cambridge Scholars Publishing, 2015)*.

Govender, E.M., Durden, E. and Reddy, S., 2010. How participatory is participatory communication for HIV/AIDS awareness in South Africa. *African Communication Research*, *3*(2), pp.281-303.

Guha, Saurav & Rosenfeld, Jeffrey & Malhotra, Anil & Lee, Annette & Gregersen, Peter & Kane, John & Pe'er, Itsik & Darvasi, Ariel & Lencz, Todd. 2012. Implications for health and disease in the genetic signature of the Ashkenazi Jewish population. Genome Biology. 10.1186/gb-2012-13-1-r2.

Gupta, D., Jai P, N. and Yadav, S.J., 2021. Strategic communication in health and development: concepts, applications and programming. *Journal of Health Management*,*23*(1), pp.95-108.

Gupta A, Mehra P, Dhar SK. 2008. Plasmodium falciparum origin recognition complex subunit 5: functional characterization and role in DNA replication foci formation. Mol Microbiol; 69(3):646-65. Doi: 10.1111/j.1365-2958.2008.06316.x. Epub 2008 Jun 28. PMID: 18554328; PMCID: PMC2610387.

Guttman, N., 1997. Beyond strategic research: A value-centred approach to health communication interventions. *Communication Theory*,*7*(2), pp.95-124.

Guttman, N., 1997. Ethical dilemmas in health campaigns. *Health Communication*,*9*(2), pp.155-190.

Gyasi, R.M., Mensah, C.M., Osei-Wusu Adjei, P. and Agyemang, S., 2011. Public perceptions of the role of traditional medicine in the health care delivery system in Ghana.

Habte, A., Dessu, S., Bogale, B. and Lemma, L., 2022. Disparities in sexual and reproductive health services utilization among urban and rural adolescents in southern Ethiopia, 2020: a comparative cross-sectional study.*BMC public health*,*22*(1), p.203.

Hadi, Marham Jupri, and Muh Junaidi. 2020. Changes and Challenges of Participating in Focus Group Discussion. Ninth International Conference on Language and Arts (ICLA 2020). Atlantis Press.

Hahn, R.A. and Inhorn, M.C., 2008. *Anthropology and public health: bridging differences in culture and society*. Oxford University Press.

Haider, M., Shannon, R. and Moschis, G.P., 2022. Sustainable consumption research and the role of marketing: A review of the literature (1976–2021). *Sustainability*, *14*(7), p.3999.

Haile, K.T., Ayele, A.A., Mekuria, A.B., Demeke, C.A., Gebresillassie, B.M. and Erku, D.A., 2017. Traditional herbal medicine use among people living with HIV/AIDS in Gondar, Ethiopia: do their health care providers know?. *Complementary therapies in medicine*, *35*, pp.14-19.

Halperin, D.T. and Epstein, H., 2004. Concurrent sexual partnerships help to explain Africa's high HIV prevalence: implications for prevention. *The Lancet*, *364*(9428), pp.4-6.

Hall, S. ed., 1997. *Representation: Cultural representations and signifying practices* (Vol. 2). Sage.

Hamidi, A., Regmi, P. and van Teijlingen, E., 2023. Facilitators and barriers to condom use in Middle East and North Africa: a systematic review. *Journal of Public Health*, pp.1-31.

Harrell, M.C. and Bradley, M., 2009. Data collection methods: Semi-structured interviews and focus groups.

Hartwig, Kari & Kissioki, Seelah & Hartwig, C.2006. Church leaders confront HIV/AIDS and stigma: A case study from Tanzania. Journal of Community & Applied Social Psychology. 16. 492 - 497. 10.1002/casp.897.

Hawkins, Robert & Kreuter, Matthew & Resnicow, Ken & Fishbein, Martin & Dijkstra, A. 2008. Understanding tailoring in communicating about health. Health education research. 23. 454-66. 10.1093/her/cyn004.

Helleringer, S. and Kohler, H.P., 2007. Sexual network structure and the spread of HIV in Africa: evidence from Likoma Island, Malawi.*Aids*,*21*(17), pp.2323-2332.

Herrera, P.M., Davies, J. and Baena, P.M. eds., 2014.*The Governance of Rangelands: collective action for sustainable pastoralism*. Routledge.

Herrero, M., Addison, J., Bedelian, C., Carabine, E., Havlík, P., Henderson, B., Van De Steeg, J. and Thornton, P.K., 2016. Climate change and pastoralism: impacts, consequences and adaptation.*RevueScientifiqueETTechnique*,*35*(2), pp.417-433.

Hess, R.F. and McKinney, D., 2007. Fatalism and HIV/AIDS beliefs in rural Mali, West Africa. *Journal of Nursing scholarship*, *39*(2), pp.113-118.

Hussein, J.W., 2004. A cultural representation of women in the Oromo society. *African study monographs*, *25*(3), pp.103-147.

Heu, L.C., van Zomeren, M. and Hansen, N., 2019. Lonely alone or lonely together? A cultural-psychological examination of individualism–collectivism and loneliness in five European countries. *Personality and Social Psychology Bulletin*,*45*(5), pp.780-793.

HIV prevention: A review of international research. *AIDS,* 14: S22–S32.

Hofstede, G., Hofstede, G.J. and Minkov, M.2012. Cultures and Organizations: Software of the mind.

Hofstede, G., & Bond, M. H. 1984. Hofstede's culture dimensions: An independent validation using Rokeach's value survey. Journal of cross-cultural psychology, 15(4), 417-433.

Honarvar, B., Jalalpour, A.H., Shaygani, F., Eghlidos, Z., Jahangiri, S., Dehghan, Y., Poreisa, M.J. and Rafiei, F., 2022. Knowledge, Attitudes, Threat Perception, and Practices toward HIV/AIDS among Youths in Iran: A Health Belief Model–Based Systematic Review. *Shiraz E-Medical Journal*, *23*(6).

Homsy, J., King, R., Balaba, D. and Kabatesi, D., 2004. Traditional health practitioners are key to scaling up comprehensive care for HIV/AIDS in sub-Saharan Africa. *Aids*, *18*(12), pp.1723-1725.

Hood, S., Campbell, B. and Baker, K., 2023. Culturally Informed Community Engagement: Implications for Inclusive Science and Health Equity.*RTI Press*.

Hordofa, K., 2001. Linguistic relationship between Oromo, Sidama, Kambata, Hadiya and Gedeo.*Wiirtuu, Journal of Oromo Language Standardization*,*6*, pp.164-173.

Hosek, S. and Pettifor, A., 2019. HIV prevention interventions for adolescents. *Current HIV/AIDS Reports*,*16*, pp.120-128.

Hovland, O.J., Hole, A.F., Chiduo, M.G. and Johannessen, B., 2021. Experiences from cross-cultural collaboration in health campaigns in Tanzania: a qualitative study.*Archives of Public Health*,*9*(1), pp.1-8.

Idler, E.L. ed., 2014. *Religion as a social determinant of public health*. Oxford University Press, USA.

Ilwoo Ju, Jennifer Ohs, Taehwan Park & Amber H. 2023. Harnessing an Integrated Health Communication (IHC) Framework for Campaigns: A Case of Prescription Drug Decision Making, Health Communication, 38:5, 981-992, DOI: 10.1080/10410236.2021.1986885.

Institute of Medicine, Board on Neuroscience and Behavioural Health and Committee on Communication for Behaviours Change in the 21st Century: Improving the Health of Diverse Populations, 2002. *Speaking of health: assessing health communication strategies for diverse populations*. National Academies Press.

Iqbal, M. and Zahidie, A., 2022. Diffusion of innovations: a guiding framework for public health. *Scandinavian journal of public health*,*50*(5), pp.533-537.

Isangula, K.G and Isangula, K.G., 2011. A Conceptual Framework for Factors Associated with HIV Infection Risk: A Life Course Perspective.

Ishikawa, H. and Kiuchi, T., 2010. Health literacy and health communication. *Bio Psychosocial medicine*, *4*, pp.1-5.

Iwelunmor, J., Newsome, V. and Airhihenbuwa, C.O., 2014. Framing the impact of culture on health: a systematic review of the PEN-3 cultural model and its application in public health research and interventions. *Ethnicity & health*, *19*(1), pp.20-46.

Jacques-Aviñó, C., Garcia de Olalla, P., Gonzalez Antelo, A., Fernandez Quevedo, M., Romaní, O., & Caylà, J. A. 2019. The theory of masculinity in studies on HIV. A systematic review. Global Public Health, 14(5), 601-620.

Jadgal, M., Heshmati, H., Keshavarz, M., Zareipour, M., Faryabi, R. and Alizadeh-Siuki, H., Effect of theory of planned behaviour-based educational intervention on HIV/AIDS preventive behaviours among male barbers.*HIV & AIDS Review. International Journal of HIV-Related Problems*,*22*(1), pp.77-83.

Jahagirdar, D., Walters, M.K., Novotney, A., Brewer, E.D., Frank, T.D., Carter, A., Biehl, M.H., Abbastabar, H., Abhilash, E.S., Abu-Gharbieh, E. and Abu-Raddad, L.J., 2021. Global, regional, and national sex-specific burden and control of the HIV epidemic, 1990–2019, for 204 countries and territories: The Global Burden of Diseases Study 2019. *The Lancet HIV*, *8*(10), pp.e633-e651.

Jain, A., Tobey, E., Ismail, H. and Erulkar, A., 2018. Condom use at last sex by young men in Ethiopia: the effect of descriptive and injunctive norms. *Reproductive Health*,*15*, pp.1-9.

Jalata, A., 1996. The struggle for knowledge: The case of emergent Oromo studies. *African Studies Review*,*39*(2), pp.95-123.

Jalata, A. and Schaffer, H., 2013. The Oromo, Gadaa/Siqqee democracy and the liberation of Ethiopian colonial subjects. *Alternative: An International Journal of Indigenous Peoples*,*9*(4), pp.277-295.

Jalata, A., 2012. Gadaa (Oromo democracy): an example of classical African Civilization. *Journal of Pan-African Studies*, p.126.

James, B. and Saville-Smith, K., 1989. Gender, culture and power: Critical issues in New Zealand society.

Jannette Berkley-Patton, Kathleen Goggin, Robin Liston, Andrea Bradley-Ewing & Sally N.2009. Adapting Effective Narrative-Based HIV-Prevention Interventions to Increase Minorities' Engagement in HIV/AIDS Services, Health Communication, 24:3, 199-209, DOI: 10.1080/10410230902804091.

Jeffries, W.L. and Henny, K.D., 2019. From epidemiology to action: the case for addressing social determinants of health to end HIV in the Southern United States. *AIDS and Behavior*,*23*, pp.340-346.

Jewkes, R. and Morrell, R., 2010. Gender and sexuality: emerging perspectives from the heterosexual epidemic in South Africa and implications for HIV risk and prevention. *Journal of the International AIDS society*, *13*, pp.1-11.

Jim, D., 2005. First Nations Regional Longitudinal Health Survey (RHS) Cultural Framework.

Jie, Ng Ding. 2016. "Towards a framework of education policy analysis." THF Literature Rev: 9781003002666-8.

Jin, H., Restar, A. and Beyrer, C., 2021. Overview of the epidemiological conditions of HIV among key populations in Africa. *Journal of the International AIDS Society*,*24*, p.e25716.

Johnson Shen, M., Freeman, R., Karpiak, S., Brennan-Ing, M., Seidel, L. and Siegler, E.L., 2019. The intersectionality of stigmas among key populations of older adults affected by HIV: a thematic analysis. *Clinical Gerontologist*,*42*(2), pp.137-149.

Joint United Nations Programme on HIV/AIDS, 2001. HIV/AIDS and communication for behaviour and social change: programme experiences, examples, and the way forward. International Workshop, UNAIDS, Department of Policy, Strategy and Research, Geneva, Switzerland, 25-27 July 2000. In *HIV/AIDS and communication for behaviour and social change: programme experiences, examples, and the way forward. International Workshop, UNAIDS, Department of Policy, Strategy and Research, Geneva, Switzerland, 25-27 July 2000.* UNAIDS.

Jones, C.J., Smith, H. and Llewellyn, C., 2014. Evaluating the effectiveness of health belief model interventions in improving adherence: a systematic review. *Health psychology review*,*8*(3), pp.253-269.

Jones, J., Salazar, L.F. and Crosby, R., 2017. Contextual factors and sexual risk behaviours among young, black men. *American journal of men's health*,*11*(3), pp.508-517.

Joshi A, Kaur M, Kaur R, Grover A, Nash D, El-Mohandes A. 2021. Predictors of COVID-19 Vaccine Acceptance, Intention, and Hesitancy: A Scoping Review. Front Public Health; 9:698111. Doi: 10.3389/fpubh.2021.698111. PMID: 34485229; PMCID: PMC8414566.

Joorbonyan, H., Ghaffari, M. and Rakhshanderou, S., 2022. Peer-led theoretically Designed HIV/AIDS prevention intervention among students: a case of health belief model *public Health*,*22*(1), pp.1-10.

Jovchelovitch, S. and Bauer, M.W., 2000. Narrative interviewing. Qualitative researching with text, image and sound, 57, p.74.

Kaba, M., 2022. Systems Thinking for Pastoral Health. *Systems Thinking for Global Health: How can systems-thinking contribute to solving key challenges in Global Health?* p.246.

Kaba, M. 2019. Vulnerability to HIV infection among the Borana pastoral community of Southern Ethiopia: a persisting challenge. *HIV/AIDS – Research and Palliative Care*, 11: 6-16.

Kaba M, Taye G, Gizaw M, Mitiku I, Adugna Z, Tesfaye A.2016. A qualitative study of vulnerability to HIV infection: places and persons in urban settings of Ethiopia. Ethiop J Health Dev; 30(3):105–111.

Kaba, M., 2013. Tapping local resources for HIV prevention among the Borana pastoral community. *Ethiopian Journal of Health Development*,*27*(1), pp.33-39.

Kaba, M. and Mariam, H.D., 2012. The state of HIV prevention in Borana Zone of Oromia region, southern Ethiopia. *Ethiopia Journal of Health Development*, *26*(1), pp.9-15.

Kaba, M., Ame, I. and Mariam, D.H., 2013. Extramarital sexual practices and perceived association with HIV infection among the Borana pastoral community. *Ethiopian Journal of Health Development*,*27*(1), pp.25-32.

Kagawa-Singer M, Dressler, W., George, S. And Elwood, W., 2015. The cultural framework for health. *Washington, DC: National Institute for Health*.

Kahissay, M.H., Fenta, T.G. and Boon, H., 2020. Religion, spirits, human agents and healing: A conceptual understanding from a sociocultural study of Tehuledere Community, Northeaster Ethiopia. *Journal of religion and health*,*59*, pp.946-960.

Kairania, R., Onyango-Ouma, W. and Ondicho, T.G., 2023. Socio-Cultural Influencers of Disclosure of HIV Status to Children on Antiretroviral Therapy in the Masaka Region, Uganda: A Qualitative Study. *Journal of the International Association of Providers of AIDS Care (JIAPAC)*, *22*, p.23259582231163695.

Kalichman, S.C., Benotsch, E., Suarez, T., Catz, S., Miller, J. and Rompa, D., 2000. Health literacy and health-related knowledge among persons living with HIV/AIDS. *American journal of preventive medicine*,*18*(4), pp.325-331.

Kalichman SC. Kelly JA.1995. Increased attention to human sexuality can improve HIV-AIDS; 63(6):907-18. Doi: 10.1037//0022-006x.63.6.907. PMID: 8543713.

Kaminski, J., 2011. Diffusion of Innovation Theory Canadian Journal of Nursing Informatics. *Theory in Nursing Informatics Column. [Artikkeli]*,*6*(2).

Kapadia-Kundu, N., Tamene, H., Ayele, M., Dana, F., Heliso, S., Velu, S., Berhanu, T., Alemayehu, G., Leslie, L. and Kaufman, M., 2022. Applying a gender lens to social norms, couple communication and decision making to increase modern contraceptive use in Ethiopia, a mixed methods study. *Reproductive health*, *19*(Suppl 1), p.138.

Karan, Abraar, Emily Hartford, and Thomas J. C. 2017. "The potential for political leadership in HIV/AIDS communication campaigns in Sub-Saharan Africa." Global health action 10.1: 1270525.

Kar, Snehendu & Pascual, Catherine & Chickering, Kirstin & Hazelton, T. 2013. Empowerment of Women for Health Development: A Global Perspective. World Health & Population. 4. 10.12927/whp.2001.17591.

Kassew, T., Tarekegn, G.E., Alamneh, T.S., Kassa, S.F., Liyew, B. and Terefe, B., 2023. The prevalence and determinant factors of substance use among the youth in Ethiopia: A multilevel analysis of Ethiopian Demographic and Health Survey. *Frontiers in Psychiatry*, *14*, p.1096863.

Katbi, M., Adegboye, A., Adedoyin, A., Yunusa, F., Kayode, G., Bello, M. and Dakum, P., 2018. Effect of clients strategic index case testing on community-based detection of HIV infections (STRICT study). *International Journal of Infectious Diseases*, *74*, pp.54-60.

Kaufman, M.R., Rimal, R.N., Carrasco, M., Fajobi, O., Soko, A., Limaye, R. and Mkandawire, G., 2014. Using social and behavior change communication to increase HIV testing and condom use: the Malawi BRIDGE Project. *AIDS care*,*26*(sup1), pp.S46-S49.

Kawabata, M., 2013. Is collectivism good for health promotion? Experiences of day labourers in Japan. *Global Health Promotion*,*20*(4), pp.44-51.

Kebede, B.G., Abraha, A., Andersson, R., Munthe, C., Linderholm, M., Linderholm, B. and Berbyuk Lindström, N., 2020. Communicative challenges among physicians, patients, and family caregivers in cancer care: An exploratory qualitative study in Ethiopia. *PLOSOne*,*15*(3), p. e0230309.

Kelle, U., Kühberger, C. and Bernhard, R., 2019. How to use mixed-methods and triangulation designs: An introduction to history education research. *History Education Research Journal, 16*.

Kelly, J.A., 1999. Community-level interventions are needed to prevent new HIV infections. *American Journal of Public Health*,*89*(3), pp.299-301.

Kenea, A., 2019. Education for Pastoralist Community Children in Ethiopia: Where the Opportunity Cost Defines It All. *East African Journal of Social Sciences and Humanities*,*4*(2), pp. 63-82.

Kenea Boru, Ambissa. 2023. Education for Borana pastoralist community Boru FULL-LENGTH ARTICLE Education for Borena Pastoralist Community Children in Ethiopia: Practices and Challenges. 15. 19-32.

Keogh, E., 2021. The gender context of pain. *Health Psychology Review*, *15*(3), pp.454-481.

Keshet, Y., & Popper-Giveon, A. 2019. Language practice and policy in Israeli hospitals: the case of the Hebrew and Arabic languages. Israel Journal of Health Policy Research, 8, 1-11.

Kgatle, Mookgo S. 2023. Spiritual Fathering in Pentecostal and Charismatic Christianity in Southern and Western Africa: Toward an Inclusive Model. The International Journal of Religion and Spirituality in Society. 13. 143-152. 10.18848/2154-8633/CGP/v13i01/143-152.

Khandu, L., Tobgay, T. and McFarland, W., 2021. Social, Cultural and Economic determinants of HIV/AIDS: A community case report of Bhutan.*Social Determinants of Health*,*6*, p.e28.

Kim, J.G., Hong, H.C., Lee, H., Ferrans, C.E. and Kim, E.M., 2019. Cultural beliefs about breast cancer in Vietnamese women *women's health*,*19*, pp.1-8.

Kim, S. and Kim, S., 2020. Analysis of the impact of health beliefs and resource factors on preventive behaviours against the COVID-19 pandemic. *International journal of environmental research and public health*,*17*(22), p.8666.

Kinaro, J.W., Wangalwa, G., Karanja, S., Adika, B., Lengewa, C. and Masitsa, P., 2018. Socio-Cultural Barriers Influencing Utilization of Sexual and Reproductive Health (SRH) Information and Services among Adolescents and Youth 10-24 Years in Pastoral Communities in Kenya

Kinuthia, R. 2010. The Association between Female Genital Mutilation (FGM) and the Risk of HIV/AIDS in Kenyan Girls and Women (15-49 Years).

Kippax, S., Stephenson, N., Parker, R.G. and Aggleton, P., 2013. Between individual agency and structure in HIV prevention: understanding the middle ground of social practice. American journal of public health,103(8), pp.1367-1375.

Klaas, N.E., Thupayagale-Tshweneagae, G. and Makua, T.P., 2018. The role of gender in the spread of HIV and AIDS among farmworkers in South Africa. *African Journal of Primary Health Care and Family Medicine*, *10*(1), pp.1-8.

Klionsky, D.J., Abdel-Aziz, A.K., Abdelfatah, S., Abdellatif, M., Abdoli, A., Abel, S., Abeliovich, H., Abildgaard, M.H., Abudu, Y.P., Acevedo-Arozena, A. and Adamopoulos, I.E., 2021. Guidelines for the use and interpretation of assays for monitoring autophagy. *Autophagy*, *17*(1), pp.1-382.

Klonoff, E.A., 2009. Disparities in the provision of medical care: an outcome in search of an explanation. *Journal of behavioural medicine*, *32*(1), pp.48-63.

Kloos, Helmut & Haile Mariam, Damen & Kaba, Mirgissa & Tadele, Getnet. 2013. Traditional medicine and HIV/AIDS in Ethiopia: Herbal medicine and faith healing: A review. Ethiopian Journal of Health Development. 27. 141-155.

Kloos, H., Mariam, D.H., Kaba, M. and Tadele, G., 2013. Traditional medicine and HIV/AIDS in Ethiopia: Herbal medicine and faith healing: A review. *Ethiopian Journal of Health Development*, *27*(2), pp.141-155.

Kloos, H. and Mariam, D.H., 2000. HIV/AIDS in Ethiopia: An overview. *Northeast African Studies*, pp.13-40.

Koenig, H.G., 2004. Religion, spirituality, and medicine: research findings and implications for clinical practice. *South Medical Journal*, *97*(12), pp.1194-200.

Koenig, H.G., King, D. and Carson, V.B., 2012. *Handbook of religion and health*. OupUsa.Kolié, D., Van De Pas, R., Codjia, L. and Zurn, P., 2023. Increasing the availability of health workers in rural sub-Saharan Africa: a scoping review of rural pipeline programmes. *Human Resources for Health*,*21*(1), p.20.

Kreps, G.L., 2020. The value of health communication scholarship: New directions for health communication inquiry. *International Journal of Nursing Sciences*, *7*(Suppl 1), p.S4.

Kreuter, M.W. and McClure, S.M., 2004. The role of culture in health communication. *AnnualReview ofPublic Health*,*25*, pp.439-455.

Kreuter, M.W., Lukwago, S.N., Bucholtz, D.C., Clark, E.M. and Sanders-Thompson, V., 2003. Achieving cultural appropriateness in health promotion programs: targeted and tailored approaches. *Health Education &Behaviour*, *30*(2), pp.133-146.

Krueger, R.A., 2014. Focus groups: A practical guide for applied research. Sage publications.

Krueger, RA & Casey, MA. 2000. Focus groups: practical guide for applied research .3rd edition. Thousand Oaks Calif: Sage.

Krueger, R. A. 1998. Analysing and Reporting Focus Group Results (Vol. 6). Sage Publications. https://doi.org/10.4135/9781483328157

Kuada, J. and Hinson, R.E., 2012. Corporate social responsibility (CSR) practices of foreign and local companies in Ghana. *Thunderbird International Business Review*, *54*(4), pp.521-536.

Lacey, A. and Luff, D., 2009. Qualitative research analysis: the NIHR RDS for the East Midlands/Yorkshire & the Humber; 2007.

Lagarde, E., Enel, C., Seck, K., Gueye-Ndiaye, A., Piau, J.P., Pison, G., Delaunay, V., Ndoye, I. and Mboup, S., 2000. Religion and protective behaviours towards AIDS in rural Senegal. *Aids*, *14*(13), pp.2027-2033.

Lamstein, S., Stillman, T., Koniz-Booher, P., Aakesson, A., Collaiezzi, B., Williams, T., Beall, K. and Anson, M., 2014. Evidence of effective approaches to social and behavior change communication for preventing and reducing stunting and anemia: Report from a systematic literature review. *USAID/Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) Project, Arlington*.

Larmarange, J., Diallo, M.H., McGrath, N., Iwuji, C., Plazy, M., Thiébaut, R., Tanser, F., Bärnighausen, T., Pillay, D., Dabis, F. and Orne-Gliemann, J., 2018. The impact of population dynamics on the population HIV care cascade: results from the ANRS 12249 Treatment as Prevention trial in rural KwaZulu-Natal (South Africa). *Journal of the International AIDS Society*, *21*, p.e25128.

Lawson, D.W. and Gibson, M.A., 2018. Polygynous marriage and child health in sub-Saharan Africa: what is the evidence for harm? *Demographic Research*, *39*, pp.177-208.

Leedy, P.D. and Ormrod, J.E. 2015. Practical research. Planning and design. Boston, MA: Pearson.

Leedy, P.D.and Omrod, J.E., 2006. Practical research planning and design. New Jersey: Prentice Hall.

Legesse, A., 2000. Oromo democracy: An indigenous African political system. *(No Title)*.

Legesse, A., 1973. Gada: Three approaches to the study of African society.

Leitch, C.M., Hill, F.M. and Harrison, R.T., 2010. The philosophy and practice of interpretivist research in entrepreneurship: Quality, validation, and trust. *Organizational Research Methods*, *13*(1), pp.67-84.

Lekas, H.M., Siegel, K. and Schrimshaw, E.W., 2006. Continuities and discontinuities in the experiences of felt and enacted stigma among women with HIV/AIDS. *Qualitative health research*, *16*(9), pp.1165-1190.

Lakew Y, Bekele A, Biadgilign S. 2015. Factors influencing full immunization coverage among 12-23 months of age children in Ethiopia: evidence from the national demographic and health survey in 2011. BMC Public Health. 15:728. Doi: 10.1186/s12889-015-2078-6. PMID: 26224089; PMCID: PMC4520202.

Lazuardi, Elan & Newman, Christy & Anintya, Irma & Rowe, Emily & Wirawan, D & Wisaksana, Rudi & Subronto, Yanri & Kaldor, John & Kusmayanti, Nur & Iskandar, Shelly & Bell, Stephen. 2019. Understanding the Social Influences on Engaging Key Populations with HIV Prevention: A Qualitative Study with Men Who Have Sex with

Men in Three Indonesian Cities. AIDS education and prevention: official publication of the International Society for AIDS Education. 31. 206-223. 10.1521/aeap.2019.31.3.206.

Lester, J.N., Cho, Y. and Lochmiller, C.R., 2020. Learning to do qualitative data analysis: A starting point. *Human resource development review*, *19*(1), pp.94-106.

Lettiah, Gumbo & Nendanga, Leeroy. 2020. The impact of non-verbal cues in HIV/AIDS Health Communication campaigns. Journal of AIDS and HIV Clinical Research. 1. 1-8. 10.47755/jahcr.1000101.

Lie, R., 2003. *Spaces of intercultural communication. An interdisciplinary introduction to communication, culture, and globalizing/localizing identities*. Hampton Press.

Lie, R., 2008. Rural HIV/AIDS communication/intervention: From using models to using frameworks and common principles. *Communication for development and social change*, pp.279-295.Lieber, M., Chin-Hong, P., Whittle, H.J., Hogg, R. and Weiser, S.D., 2021. The synergistic relationship between climate change and the HIV/AIDS epidemic: a conceptual framework. *AIDS and Behavior*, *25*, pp.2266-2277.

Limaye, R.J., Bingenheimer, J., Rimal, R.N., Krenn, S. and Vondrasek, C., 2013. Treatment-as-prevention in AIDS control: Why communication still matters. *Journal of Therapy and Management in HIV Infection*, *1*.

Lincoln, Y.S., Lynham, S.A. and Guba, E.G., 2011. Paradigmatic controversies, contradictions, and emerging confluences, revisited. *The Sage handbook of qualitative research*, *4*(2), pp.97-128.

Lindgren, T.G., Reyes, D., Eller, L., Wantland, D., Portillo, C., Holzemer, W.L., Matshediso, E., Corless, I., Kemppainen, J., Mogobe, K.D. and Webel, A., 2018. Understanding health literacy for people living with HIV: locations of learning. *Journal of the Association of Nurses in AIDS Care*, *29*(2), pp.190-203.

Little, C.M., 2003. Female genital circumcision: medical and cultural considerations. *Journal of cultural diversity*, *10*(1), p.30.

Livingston, I.L., 1992. AIDS/HIV crisis in developing countries: the need for greater understanding and innovative health promotion approaches. *Journal of the National Medical Association*, *84*(9), p.755.

Logie, C.H., Okumu, M., Mwima, S. 2019. Social ecological factors associated with experiencing violence among urban refugee and displaced adolescent girls and young women in informal settlements in Kampala, Uganda: a cross-sectional study. Confl Health 13, 60. https://doi.org/10.1186/s13031-019-0242-9.

Loncar, D., Izazola-Licea, J.A. and Krishnakumar, J., 2023. Exploring relationships between HIV programme outcomes and the societal enabling environment: A structural

equation 331odelling statistical analysis in 138 low-and middle-income countries. *PLOS Global Public Health*, *3*(5), p. e0001864.

Look, M.A., Maskarinec, G.G., de Silva, M., Werner, K., Mabellos, T., Palakiko, D.M., Haumea, S.L., Gonsalves, J., Seabury, A.A., Vegas, J.K. and Solatorio, C., 2023. Developing culturally responsive health promotion: insights from cultural experts. *Health Promotion International*, *38*(2), p.022.

Lopez Vera, A., Thomas, K., Trinh, C. and Nausheen, F., 2023. A Case Study of the Impact of Language Concordance on Patient Care, Satisfaction, and Comfort with Sharing Sensitive Information During Medical Care. *Journal of Immigrant and Minority Health*, pp.1-9.

Lumborg, S., Tefera, S., Munslow, B. and Mor, S.M., 2021. Examining local perspectives on the influence of climate change on the health of Hamer pastoralists and their livestock in Ethiopia. *Pastoralism*, *11*(1), pp.1-17.

Lynn, V.A., 2017. Language and HIV communication. *HIV AIDS-Research and Palliative Care,*pp.183-185.

Mabumba, E.D., Mugyenyi, P., Batwala, V., Mulogo, E.M., Mirembe, J., Khan, F.A. and Liljestrand, J., 2007. Widow inheritance and HIV/AIDS in rural Uganda. *Tropical doctor*, *37*(4), pp.229-231.

Mabweazara, S.Z., Ley, C. and Leach, L.L., 2018. Physical activity, social support and socio-economic status amongst persons living with HIV and AIDS: a review. *African Journal of AIDS Research*, *17*(2), pp.203-212.

McCarthy GM, MacDonald JK.1996. Gender differences in characteristics, infection control practices, knowledge and attitudes related to HIV among Ontario dentists. Community Dent Oral Epidemiology; 24(6):412-5. Doi: 10.1111/j.1600-0528.1996.tb00890.x. PMID: 9007360.

Mack, N., Woodsong, C., MacQueen, K., Guest, G. and Namey, E. 2005. Qualitative Research Methods: A Data Collector's Field Guide. Family Health International (FHI), USA.

Madiba, S. and Ngwenya, N., 2017. Cultural practices, gender inequality and inconsistent condom use increase vulnerability to HIV infection: narratives from married and cohabiting women in rural communities in Mpumalanga province, South Africa. *Global health action*, *10*(sup2), p.1341597.

Madlala, S.T. and Khanyile, S., 2023. The roles of churches in HIV prevention among youth at Nqutu in KwaZulu-Natal South Africa.*Curationis*,*46*(1), pp.1-9.

Maes, Cheryl A., and Margaret L.2011. "Nurse practitioners' sexual history-taking practices with adults 50 and older." The Journal for Nurse Practitioners 7.3 (2011): 216-222.

Mah, T.L. and Halperin, D.T., 2010. The evidence for the role of concurrent partnerships in Africa's HIV epidemics: a response to Lurie and Rosenthal.*AIDS and Behavior*,*14*, pp.25-28.

Mah, T.L. and Halperin, D.T., 2010. Concurrent sexual partnerships and the HIV epidemics in Africa: evidence to move forward. *AIDS and Behavior*,*14*, pp.11-16.

Mahapatra, T., 2014. Role of information, education and communication materials in HIV control: A perspective.*Annals of Tropical Medicine and Public Health*,*7*(1), pp.3-3.

Makalela, L. 2015. Narrative interpretation of HIV/AIDS messages: The effects of storytelling prompts among rural university students. Critical Arts. 29. 400-418. 10.1080/02560046.2015.1059555.

Makoae, L.N., Greeff, M., Phetlhu, R.D., Uys, L.R., Naidoo, J.R., Kohi, T.W., Dlamini, P.S., Chirwa, M.L. and Holzemer, W.L., 2008. Coping with HIV-related stigma in five African countries. *Journal of the Association of Nurses in AIDS Care*, *19*(2), pp.137-146.

Mamo, A., Morankar, S., Asfaw, S. 2019. How do community health actors explain their roles? Exploring the roles of community health actors in promoting maternal health services in rural Ethiopia. BMC Health Serv Res 19, 724. https://doi.org/10.1186/s12913-019-4546-7.

Manqele, N.S., Selier, S.J. and Downs, C.T., 2023. The ethnomedicinal use of vultures by traditional health practitioners in KwaZulu-Natal, South Africa. *Journal of Ornithology*, pp.1-12.

Mapingure, M., Mukandavire, Z., Chingombe, I., Cuadros, D., Mutenherwa, F., Mugurungi, O. and Musuka, G., 2021. Understanding HIV and associated risk factors among religious groups in Zimbabwe. *BMC public health*, *21*, pp.1-10.

Mariam Rawan A. 2018. Culture, Religion, and Freedom of Religion or Belief, The Review of Faith & International Affairs, 16:4, 102-115, DOI: 10.1080/15570274.2018.1535033.

Marissa Becker, Mishra S, Aral S, Bhattacharjee P, Lorway R, Green K, Anthony J, Isac S, Emmanuel F, Musyoki H, Lazarus L, Thompson LH, Cheuk E, Blanchard JF. 2013. The contributions and future direction of Program Science in HIV/STI prevention. Emerg Themes Epidemiol; 15:7. doi: 10.1186/s12982-018-0076-8. PMID: 29872450; PMCID: PMC5972407.

Martial, De Salviac.2005. An Ancient People: Great African Nation: the Oromo. Translation from the 1901 original French edition by Ayalew Kanno. Paris, the French Academy.

Marmot, M. and Wilkinson, R. eds., 2005. *Social determinants of health*. Oup Oxford.

Marshall, C and Rossman, G.B.,1995. *Designing qualitative research*. Sage publications.

Marsiglio, W., 1998. *Procreative man*. NYU Press.

Mason, J. 1996. Qualitative researching. London: Sage.

Masquelier, B. and Reniers, G., 2018. AIDS and the gender gap in life expectancy in Africa. *Population Societies*, *554*(4), pp.1-4.

Maulide Cane, R., Melesse, D.Y., Kayeyi, N., Manu, A., Wado, Y.D., Barros, A. and Boerma, T., 2021. HIV trends and disparities by gender and urban–rural residence among adolescents in sub-Saharan Africa. *Reproductive health*, *18*, pp.1-10.

Mauro, P. M., Philbin, M. M., Greene, E. R., Diaz, J. E., Askari, M. S., & Martins, S. S. 2022. Daily cannabis use, cannabis use disorder, and any medical cannabis use among US adults: associations within racial, ethnic, and sexual minoritized identities in a changing policy context. Preventive Medicine Reports, 28, 101822.

Mayring, P., 2002. Qualitative content analysis–research instrument or mode of interpretation. *The role of the researcher in qualitative psychology*, *2*(139-148).

Mays, V.M., Cochran, S.D. and Zamudio, A., 2004. HIV prevention research: Are we meeting the needs of African American men who have sex with men?. *Journal of Black Psychology*, *30*(1), pp.78-105.

Mbengo, F., Zgambo, M., Afrifa-Yamoah, E., Kalembo, F.W., Honda, T., Shimpuku, Y. and Chen, S., 2022. Systematic review protocol of the effectiveness of HIV prevention interventions for reducing risky sexual behaviour among youth globally. *BMJ open*, *12*(5), p.e056929.

Mbonye, M., Nalukenge, W., Nakamanya, S., Nalusiba, B., King, R., Vandepitte, J. and Seeley, J., 2012. Gender inequity in the lives of women involved in sex work in Kampala, Uganda. *Journal of the international AIDS society*, *15*, p.17365.

McKee, N., Bertrand, J., Becker-Benton, A. and Becker, B.L., 2004. *Strategic communication in the HIV/AIDS epidemic*. Sage.

Medved Kendrick, H., 2017. Are religion and spirituality barriers or facilitators to treatment for HIV: a systematic review of the literature. *AIDS care*, *29*(1), pp.1-13.

Megersa, B., Markemann, A., Angassa, A., Ogutu, J.O., Piepho, H.-P. and Zaráte, A.V. 2014. Impacts of climate change and variability on cattle production in southern Ethiopia: Perceptions and empirical evidence. Agricultural Systems 130:23-24.

Mekonnen, T.H. and Yenealem, D.G., 2019. Factors affecting healthcare utilization for low back pain among nurses in Gondar town, Northwest Ethiopia, 2018: a cross-sectional study. *BMC research notes*, *12*, pp.1-6.

Mela R. 2014. Know Your HIV Epidemic/Know Your HIV Response (KYE/KYR) Synthesis in Oromia, Ethiopia.

Melese, G., Tesfa, M., Sharew, Y. 2018. Knowledge, attitude, practice, and predictors of female genital mutilation in Degadamot district, Amhara regional state, Northwest Ethiopia, 2018. BMC Women's Health 20, 178 (2020). https://doi.org/10.1186/s12905-020-01041-2.

Mertens, D.M., 2008. *Transformative research and evaluation*. Guilford press.

Mgbako, O., Conard, R., Mellins, C.A., Dacus, J.D. and Remien, R.H., 2022. A systematic review of factors critical for hiv health literacy, ART adherence and retention in care in the US for racial and ethnic minorities. *AIDS and Behavior*, *26*(11), pp.3480-3493.

Mhungu, A., Sixsmith, J. and Burnett, E., 2023. Adolescent Girls and Young Women's Experiences of Living with HIV in the Context of Patriarchal Culture in Sub-Saharan Africa: A Scoping Review. *AIDS and Behaviour*, *27*(5), pp.1365-1379.

Michal-Johnson, P., & Bowen, S. P. 1992. The place of culture in HIV education. In T. Edgar, M. A. Fitzpatrick, & V. S. Freimuth (Eds.), AIDS: A communication perspective (pp. 147–172). Lawrence Erlbaum Associates, Inc.

Mike, J.H., 2020. Access to essential medicines to guarantee women's rights to health: The pharmaceutical patents connection. *The Journal of World Intellectual Property*, *23*(3-4), pp.473-517.

Miller, J.E., Guarnaccia, P.J. and Fasina, A., 2002. AIDS knowledge among Latinos: The role of language, culture, and socio-economic status. *Journal of Immigrant Health*, pp.63-72.

Ministry of Education. 2013. Communication Strategy on HIV/AIDS and Sexual Reproductive Health (SRH) For Higher Education Institutions. Higher Education Institutions' partnership in Sub-forum against HIV/AIDS, Ethiopia, Addis Ababa.

Ministry of Health of Ethiopia. 2018. HIV Prevention in Ethiopia National Road Map 2018 – 2020, Federal HIV/AIDS Prevention, and Control Office of Ethiopia Addis Ababa.

Mirkuzie, A.H., Ali, S., Abate, E., Worku, A. and Misganaw, A., 2021. Progress towards the 2020 fast track HIV/AIDS reduction targets across ages in Ethiopia as compared to neighbouring countries using global burden of diseases 2017 data. *BMC Public Health*, *21*, pp.1-10.

Mishra, Vinod & Hong, Rathavuth & Bignami, Simona & Barrere, B. 2009. The Role of Partner Reduction and Faithfulness in HIV Prevention in Sub-Saharan Africa: Evidence from Cameroon, Rwanda, Uganda, and Zimbabwe.

Misra, R., Kaster, E.C., 2012. Health Beliefs. In: Loue, S. and Sajatovic, M. eds.,*Encyclopedia of Immigrant Health* (Vol. 1). Springer Science & Business Media.

Mitike, G., Lemma, W., Berhane, F., Ayele, R., Assefa, A.T., Michael, T., Enqusellase, F., Alem, A., Abebe, Y. and Kebede, D., 2002. HIV/AIDS behavioural surveillance survey. *Addis Ababa, Ethiopia: Ministry of Health*, p.143.

Mitiku, S., Mossie, A. and Fekadu, S., 2012. Substance use and sexually transmitted infections among anti-retroviral treatment attendees in Jimma University Specialized Hospital, Jimma, Ethiopia. *Ethiopian journal of health sciences*, *22*(3), p.181.

Miz-Hasab Research Centre. 2004. HIV/AIDS and gender in Ethiopia: The case of 10 woredas in Oromia and SNNPR. Addis Ababa, Ethiopia.

Moat KA, Lavis JN, Abelson J.2013. How contexts and issues influence the use of policy-relevant research syntheses: a critical interpretive synthesis. Milbank Q.; 91(3):604-48. Doi: 10.1111/1468-0009.12026. PMID: 24028700; PMCID: PMC3790526.

Moen, T., 2006. Reflections on the In-depth Research Approach. *International Journal of Qualitative Methods*, *5*(4), pp.56-69.

Moghaddam, E.S., Shahnazi, H. and Hassanzadeh, A., 2019. Predictive power of PEN-3 model constructs in breast cancer screening behaviors among teachers: a cross-sectional study in Central Iran. *European journal of breast health*, *15*(2), p.105.

Mohamed, A.A., 2019. Pastoralism and development policy in Ethiopia: a review study. *Budapest International Research and Critics Institute-Journal*, *2*(4), pp.01-11.

Mohammed, K., Nolan, M.B., Rajjo, T., Shah, N.D., Prokop, L.J., Varkey, P. and Murad, M.H., 2016. Creating a patient-centered health care delivery system: a systematic review of health care quality from the patient perspective. *American journal of medical quality*, *31*(1), pp.12-21.

Mokhutso, R.J., 2021. The impact of African indigenous knowledge system on healthcare system in South Africa: The Covid-19 perspective. *Gender and Behaviour*, *19*(1), pp.17713-17728.

Monjok, E., Essien, E.J. and Holmes, L., 2007. Female genital mutilation: potential for HIV transmission in sub-Saharan Africa and prospect for epidemiologic investigation and intervention. *African journal of reproductive health*, *11*(1), pp.33-42.

Monod, Mélodie & Brizzi, Andrea & Galiwango, Ronald & Ssekubugu, Robert & Chen, Yu & Xi, Xiaoyue & Kankaka, Edward & Ssempijja, Victor & Abeler-Dörner, Lucie & Akullian, Adam & Blenkinsop, Alexandra & Chang, Larry & Dan, Shozen & Fraser, Christophe & Golubchik, Tanya & Gray, Ronald & Hall, Matthew & Jackson, Jade & Ratmann, Oliver. 2023. 2023. Growing gender disparity in HIV infection in Africa: sources and policy implications. medRxiv : the preprint server for health sciences. 10.1101/2023.03.16.23287351.

Monteiro DD, Reichow JRC, Sais EF, Fernandes FS. 2020. Espiritualidade/religiosidade e saúde mental no Brasil: umarevisão*. Bol Acad Paul Psicol*, 40(98):129–39.

Moola, S., 2010. *A Qualitative Analysis of the Communication Process Between HIV-positive Patients and Medical Staff: A Study at Stanger Regional Hospital's Antiretrovial Therapy Clinic* (Doctoral dissertation, University of South Africa)

Morgan-Fleming, B., Riegle, S. and Fryer, W., 2007. Handbook of In-depth Inquiry: Mapping a Methodology. SAGE Publications, Inc.

Morgan, J., & Fonseca, M. 2004. Multiple Intelligence Theory and Foreign Language Learning: A Brain-based Perspective. International Journal of English Studies, 4, 119-136.

Morris, N., 2003. A comparative analysis of the diffusion and participatory models in development communication. *Communication Theory*, *13*(2), pp.225-248.

Morton, J., 2006. Conceptualising the links between HIV/AIDS and pastoralist livelihoods. *The European Journal of Development Research*, *18*, pp.235-254.

Moshabela, M., Bukenya, D., Darong, G., Wamoyi, J., McLean, E., Skovdal, M., Ddaaki, W., Ondeng'e, K., Bonnington, O., Seeley, J. and Hosegood, V., 2017. Traditional healers, faith healers and medical practitioners: the contribution of medical pluralism to bottlenecks along the cascade of care for HIV/AIDS in Eastern and Southern Africa. *Sexually transmitted infections*, *93*(Suppl 3).

Mpondo, F., Ruiter, R.A., van den Borne, B. and Reddy, P.S., 2015. Self-determination and gender-power relations as predictors of condom use self-efficacy among South African women. *Health Psychology Open*, *2*(2), p.2055102915598676.

Mswela, M., 2009. Cultural practices and HIV in South Africa: a legal perspective. *Potchefstroom Electronic Law Journal*, *12*(4).

Mtenga, S.M., Geubbels, E., Tanner, M., Merten, S. and Pfeiffer, C., 2016. It is not expected for married couples: a qualitative study on challenges to safer sex communication among polygamous and monogamous partners in south-eastern Tanzania. *Global health action*, *9*(1), p.32326.

Mtenga, S.M., Pfeiffer, C., Tanner, M., Geubbels, E. and Merten, S., 2018. Linking gender, extramarital affairs, and HIV: a mixed methods study on contextual determinants of extramarital affairs in rural Tanzania. *AIDS research and therapy*, *15*(1), pp.1-17.

Mubangizi, J.C., 2015. An assessment of the constitutional, legislative and judicial measures against harmful cultural practices that violate sexual and reproductive rights of women in South Africa. *Journal of International Women's Studies*, *16*(3), pp.158-173.

Mueller, R.A., 2019. Episodic narrative interview: Capturing stories of experience with a methods fusion. *International Journal of Qualitative Methods*, *18*, p.1609406919866044.

Mukumbang, F.C., Van Belle, S., Marchal, B. and van Wyk, B., 2017. An exploration of group-based HIV/AIDS treatment and care models in Sub-Saharan Africa using a realist evaluation (Intervention-Context-Actor-Mechanism-Outcome) heuristic tool: a systematic review. *Implementation Science*, *12*(1), pp.1-20.

Munodawafa, D., Ford, C., Oni, T., and Agyemang, C., 2020. Culture matters in communicating the global response to Covid-19. *PCD Staff*, *17*, p.E60.

Munyaradzi Kenneth, D., Marvellous, M., Stanzia, M. and Memory, D.M., 2016. Praying until death: apostolicism, delays and maternal mortality in Zimbabwe. *PLOS One*, *11*(8), p.e0160170.

Musheke, M., Bond, V. and Merten, S., 2012. Individual and contextual factors influencing patient attrition from antiretroviral therapy care in an urban community of Lusaka, Zambia. *Journal of the International AIDS Society*, *15*, p.17366.

Muthathi, I.S., Levin, J. and Rispel, L.C., 2020. Decision space and participation of primary healthcare facility managers in the Ideal Clinic Realisation and Maintenance programme in two South African provinces. *Health Policy and Planning*, *35*(3), pp.302-312.

Muthoni, C.N., Kneipp, S.M., Gichane, M.W., Caiola, C.E., Pettifor, A.E. and Williams, J.R., 2020. A systematic review of HIV interventions for young women in sub-Saharan Africa. *AIDS and Behavior*, *24*, pp.3395-3413.

Muturi, N.W., 2005. Communication for HIV/AIDS prevention in Kenya: Social-cultural considerations. *Journal of health communication*, *10*(1), pp.77-98.

Muudee, H.M., 1995. Hamid MuudeesOromo Dictionary, Vol. I. *Sagalee Oromoo Publishing, Atlanta*.

Mwaka, A.D., Achan, J. and Orach, C.G., 2023. Traditional health practices: A qualitative inquiry among traditional health practitioners in northern Uganda on becoming a healer, perceived causes of illnesses, and diagnostic approaches. *PLOSOne*, *18*(4), p.e0282491.

Mwambene, L., 2017. What is the future of polygyny (polygamy) in Africa? *Potchefstroom Electronic Law Journal/Potchefstroomse Elektroniese Regsblad*, *20*(1).

Nabarro, D., 2017. Including communities in public health action: harnessing best practices. *Journal of Health Communication*, *22*(sup1), pp.1-1

National AIDS Council. 2000. National AIDS Council Draft Document. Addis Ababa: National AIDS Council document.

National AIDS Council. 2001. Strategic framework for the national response to HIV/AIDS in Ethiopia (2001–2005). Addis Ababa: National AIDS Council document.

National Cancer Institute (NCI). 1989. *Making Health Communications Work. Publication. Number. NIH 89-1493*. Washington, DC: U.S. Department of Health and Human Services (HHS).

National Institute of Health Report. 2015. The cultural framework for health: An integrative approach for research and program design and evaluation.

National Research Council, 1996. *Preventing and mitigating AIDS in Sub-Saharan Africa: Research and data priorities for the social and behavioural sciences*. National Academies Press.

Ned, L., Kpobi, L. and Ohajunwa, C., 2021. Thinking about mental health and spirituality from the indigenous knowledge systems frame of reference. *Disability Studies Quarterly*, *41*(4).

Neduzhko, O., Saliuk, T., Kovtun, O., Semchuk, N. and Varetska, O., 2023. Community-based HIV prevention services for transgender people in Ukraine: current situation and potential for improvement. *BMC Health Services Research*, *23*(1), p.631.

Nelson, A.R., Smedley, B.D. and Stith, A.Y., 2003. Institute of Medicine. Unequal treatment: confronting racial and ethnic disparities in health care.

Neuman, W.L., 2000. *Workbook for social research methods: Qualitative and quantitative Approaches*. Allyn and Bacon.

Ndlovu, S., 2023. Indigenous Knowledge Systems in Africa: exclusion of students with disabilities in South African higher education. *Curriculum Perspectives*, pp.1-14.

Nguyen, H.V., Le, G.M., Nguyen, S.M., Tran, M.N. and Ha, N.M., 2012. The effect of participatory community communication on HIV preventive behaviours among ethnic minority youth in central Vietnam. *BMC Public Health*, *12*(1), pp.1-11.

Niëns, L. and Lowery, D., 2009. Gendered epidemiology: Sexual equality and the prevalence of HIV/AIDS in Sub-Saharan Africa. *Social Science Quarterly*, *90*(5), pp.1134-1144.

Nicholas, L. 2003. Introduction to Psychology. Cape Town: University of Cape Town Press.

Nirupama N. 2008.Vulnerability and risk perception in the management of HIV/AIDS: public priorities in a global pandemic. Risk Manage Health Policy; 1:7–14.

Nissen, V. and Meuter, R.F., 2023. The impact of bilinguality and language context on the understanding of epistemic adverbs in health communication: the case of English and Russian. *Frontiers in Psychology*, *14*, p.1179341.

Noble, H. and Smith, J., 2015. Issues of validity and reliability in qualitative research. *Evidence-based nursing*, *18*(2), pp.34-35.

Nyindo, M., 2005. Complementary factors contributing to the rapid spread of HIV-I in sub-Saharan Africa: a review. *East African medical journal*, *82*(1).

Nyumba, Tobias & Wilson, † & Derrick, Christina & Mukherjee, N. 2018. The use of focus group discussion methodology: Insights from two decades of application in conservation. Methods in Ecology and Evolution. 9. 20-32. 10.1111/2041-210X.12860.

Nweze, N. B., Unaogu, N. N., Ubochi, V. N., Inechi, C. M., Onwukwe, J. U., Onu, J. U., & Ohaeri, J. U. 2018. Morbid risk of schizophrenia amongst relatives of schizophrenia probands: A family-controlled study. South African Journal of Psychiatry, 24(1), 1-6.

Oba, G.,1990. Changing property rights among settling pastoralists: an adaptive strategy to declining pastoral resources. *Property, Poverty and People: Changing Rights in Property and Problems of Pastoral Development, Department of Social Anthropology, University of Manchester*.

Obregon, C.O.A.R., 2000. A critical assessment of theories/models used in health communication for HIV/AIDS. *Journal of health communication*, *5*(Sup1), pp.5-15.

O'Brien, D., 2016. *An introduction to the Theory of Knowledge*. John Wiley & Sons.

Ochillo, M.A., Van Teijlingen, E. and Hind, M., 2017. Influence of faith-based organisations on HIV prevention strategies in Africa: a systematic review. *African health sciences*, *17*(3), pp.753-761.

Ochs, Elinor & Kremer-Sadlik, Tamar & Solomon, Olga & Sirota, Karen. 2001. Inclusion as Social Practice: Views of Children with Autism. Social Development. 10. 399 - 419. 10.1111/1467-9507.00172.

Octavia, A., 2018. The impact of social marketing mix and message effectiveness to target audience behaviour of HIV/Aids. *KnE Social Sciences*.

OHCHR, W., 2022. The right to health: fact sheet No. 31.

Okechi, O.S., 2018. The indigenous concept of sexuality in African tradition and globalization. *Global Journal of reproductive medicine*, *6*(1), pp.1-5.

Okidu, O., 2013. A comparative study of two communication models in HIV/AIDS coverage in selected Nigerian newspapers. *Global health action*, *6*(1), p.18993.

Okoro, O.N., Nelson, C.S., Witherspoon, S.P., Witherspoon, S.F. and Simmons Jr, G.E., 2020. Culturally responsive health promotion to address health disparities in African American men: A program impact evaluation. *American Journal of Men's Health*, *14*(4), p.1557988320951321.

Oladipo, O. 2021. Developing outstanding Research topics. https://www.researchgate.net/post/Developing_outstanding_Research_topics/61115d213ffec4 32b49d21e/citation/download.

Oladimeji, K.E., Dzomba, A., Adetokunboh, O., Zungu, L., Yaya, S. and Ter Goon, D., 2020. Epidemiology of multimorbidity among people living with HIV in sub-Saharan Africa: a systematic review protocol. *BMJ open*, *10*(12), p.e036988.

Olaore, I.B. and Olaore, A.Y., 2014. Is HIV/AIDS a consequence or divine judgment? Implications for faith-based social services. A Nigerian faith-based university's study. *Sahara-J: Journal of Social Aspects of Hiv/Aids*, *11*(1), pp.20-25.

Olaoye, A. and Onyenankeya, K., 2023. A systematic review of health communication strategies in Sub-Saharan Africa-2015-2022. *Health Promotion Perspectives*, *13*(1), p.10.

Olufowote, J.O., 2021. Taking culture and context seriously: advancing health communication research on HIV/AIDS prevention in Tanzania with the PEN-3 cultural model. *Howard Journal of Communications*, *32*(4), pp.394-412.

Omar, M. and Mohamed, K., 2006. HIV/AIDS and female genital mutilation in the Somali's nomads of eastern Ethiopia: a discussion paper. *World Hospitals and Health Services: the Official Journal of the International Hospital Federation*, *42*(3), pp.27-31.

Omodara, D.A, Gibson, L. and Bowpitt, G., 2022. Exploring the impact of cultural beliefs in the self-management of type 2 diabetes among Black sub-Saharan Africans in the UK—a qualitative study informed by the PEN-3 cultural model. *Ethnicity & Health, 27*(6), pp.1358-1376.

O'Reilly, K. R., d'Aquila, E., Fonner, V., Kennedy, C., & Sweat, M. 2017. Can policy interventions affect HIV-related behaviours? A systematic review of the evidence from low-and middle-income countries. AIDS and Behaviour, 21, 626-642.

Orukwowu, U., George, B.I. and Ene-Peter, J., 2022. The knowledge, behaviour, attitudes and perception of young Nigerian adults towards HIV/AIDS and its prevention: A systematic review. *IPS Journal of Basic and Clinical Medicine*, *1*(1), pp.1-12.

Osborn, C.Y., Paasche-Orlow, M.K., Davis, T.C. and Wolf, M.S., 2007. Health Literacy: an overlooked factor in understanding HIV health disparities. *American Journal of preventive medicine*, *33*(5), pp.374-378.

O'Sullivan, G.A., Yonkler, J.A., Morgan, W. and Merritt, A.P., 2003. A field guide to designing a health communication strategy. *Baltimore: Johns Hopkins Bloomberg School of Public Health/Centre for Communication Programs*.

Owusu-Ansah, F.E. and Mji, G., 2013. African indigenous knowledge and research. *African Journal of Disability*, *2*(1), pp.1-5.

Oxfam, G.B., 2008. *HIV and AIDS*. Oxfam.

Oxman, A.D., Fretheim, A., Lewin, S., Flottorp, S., Glenton, C., Helleve, A., Vestrheim, D.F., Iversen, B.G. and Rosenbaum, S.E., 2022. Health communication in and out of public

health emergencies: to persuade or to inform? *Health research policy and systems*, *20*(1), pp.1-9.

Page, S., 2019. *Development, sexual cultural practices and HIV/AIDS in Africa* (p. 205). Springer Nature.

Pak, A., McBryde, E. and Adegboye, O.A., 2021. Does high public trust amplify compliance with stringent COVID-19 government health guidelines? A multi-country analysis using data from 102,627 individuals. *Risk Management and Healthcare Policy*, pp.293-302.

Panford, S., Nyaney, M.O., Amoah, S.O. and Aidoo, N.G., 2001. Using folk media in HIV/AIDS prevention in rural Ghana. *American journal of public health*, *91*(10), pp.1559-1562.

Panos. 2001. Background Paper for Communication for Development Roundtable. November: Nicaragua.

Pargament, K.I., Ano, G.G. and Wachholtz, A., 2005. The religious dimension of coping. *Handbook of the psychology of religion and spirituality*, pp.479-495.

Parker, W.M. and Becker-Benton, A., 2016. Experiences in conducting participatory communication research for HIV prevention globally: translating critical dialog into action through action media. *Frontiers in Public Health*, *4*, p.128.

Parker, R., 2009. Sexuality, culture and society: shifting paradigms in sexuality research. *Culture, health & sexuality*, *11*(3), pp.251-266.

Parker, W., 2006. Communication campaigns in the context of severe HIV and AIDS epidemic in South Africa.

Pastoral Communication Initiative. 2004. Meeting in Arero with Borana and Gabra elders, and Woreda, Sordu Zone and OPDC Staff, 22nd March 2004. Addis Ababa.

Passaro, R.C., Castañeda-Huaripata, A., Gonzales-Saavedra, W., Chavez-Gomez, S., Segura, E.R., Lake, J.E., Cabello, R. and Clark, J.L., 2019. Contextualizing condoms: a cross-sectional study mapping intersection of locations of sexual contact, partner type, and substance use as contexts for sexual risk behaviour among MSM in Peru. *BMC infectious diseases*, *19*(1), pp.1-12.

Patton, M.Q. 1990. Qualitative evaluation and research methods. 2nd ed., Sage Publications, Newbury Park.

Pavanello, S., 2009. Pastoralists' vulnerability in the Horn of Africa: Exploring political marginalisation, donors' policies and cross-border issues–Literature review. *Humanitarian Policy Group (HPG) Overseas Development Institute London, UK*.

Peinado, S., Treiman, K., Uhrig, J.D., Taylor, J.C. and Stryker, J.E., 2020. Effectively communicating about HIV and other health disparities: findings from a literature review and future directions. *Frontiers in communication*, *5*, p.539174.

Peprah, P., Gyasi, R.M., Adjei, P.O.W., Agyemang-Duah, W., Abalo, E.M. and Kotei, J.N.A., 2018. Religion and Health: exploration of attitudes and health perceptions of faith healing users in urban Ghana. *BMC public health*, *18*(1), pp.1-12.

Perry, B., Oluoch, L., Agot, K., Taylor, J., Onyango, J., Ouma, L., Otieno, C., Wong, C. and Corneli, A., 2014. Widow cleansing and inheritance among the Luo in Kenya: the need for additional women-centred HIV prevention options. *Journal of the International AIDS Society*, *17*(1), p.19010.

Pettifor, A., Bekker, L.G., Hosek, S., DiClemente, R., Rosenberg, M., Bull, S.S., Allison, S., Delany-Moretlwe, S., Kapogiannis, B.G. and Cowan, F., 2013. Preventing HIV among young people: research priorities for the future. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, *63*, pp.S155-S160.

Pourgholamamiji, N., Shahsavari, H., Manookian, A., Soori, T., Zandkarimkhani, M. and Zare, Z., 2023. Using theory of reasoned action to reduce high-risk sexual behaviors among patients with HPV: A randomized controlled trial. *Journal of Education and Health Promotion*, *12*.

Pophiwa, N. and Saidi, U., 2022. Approaches to embedding indigenous knowledge systems in Made in Africa Evaluations. *African Evaluation Journal*, *10*(1), p.623.

Prilutski, M.A., 2010. A brief look at effective health communication strategies in Ghana. The *Elon Journal of Undergraduate Research in Communications*, *1*, pp.51-58.

Prochaska, J.O., Johnson, S. and Lee, P., 2009. The trans theoretical model of behavior change. In S. A. Shumaker, J. K. Ockene, & K. A. Riekert (Eds.), *The handbook of health behavior change* (pp. 59–83). Springer Publishing Company.

Pulerwitz, J., Michaelis, A., Verma, R. and Weiss, E., 2010. Addressing gender dynamics and engaging men in HIV programs: lessons learned from Horizons research. *Public health reports*, *125*(2), pp.282-292.

Raeff, C., Fasoli, A.D., Reddy, V and Mascolo, M.F., 2020. The concept of culture: Introduction to spotlight series on conceptualizing culture, *Applied Developmental Science, 24*(4), pp.295-298.

Raj Aggarwal aggarwa@uakron.edu. 2011. Developing a Global Mind-set: Integrating Demographics, Sustainability, Technology, and Globalization, Journal of Teaching in International Business, 22:1, 51-69, DOI: 10.1080/08975930.2011.585920.

Ramachandran, A. 2011. Faith: Friend or Foe? The Rise of Faith Healing in Tanzania and Its Impact on Community Understanding of HIV. The Columbia University Journal of Global Health, 1(2), 3–7. https://doi.org/10.7916/thejgh.v1i2.4970.

Ramjee, G. and Daniels, B., 2013. Women and HIV in sub-Saharan Africa. *AIDS research and therapy*, *10*(1), pp.1-9.

Ramogola-Masire, D., Poku, O., Mazhani, L., Ndwapi, N., Misra, S., Arscott-Mills, T., Blank, L., Ho-Foster, A., Becker, T.D. and Yang, L., 2020. Botswana's HIV response: Policies, context, and future directions. *Journal of community psychology*, *48*(3), pp.1066-1070.

Rampton, V., Böhmer, M. and Winkler, A., 2021. Medical Technologies Past and Present: How History Helps to Understand the Digital Era. *Journal of Medical Humanities*, pp.1-22.

Rangel G. 2022. Characteristics of Culture, Customs and Traditions. J Anthropology Rep. 5:136.

Rankoana, S.A., Nel, K., Mothibi, K., Mothiba, T.M., Mamogobo, P. and Setwaba, M., 2015. The use of indigenous knowledge in primary health care: A case study of Makanye community in Limpopo Province, South Africa: Indigenous knowledge system in health care. *African Journal for Physical Health Education, Recreation and Dance*, *21*(sup-1), pp.272-278.

Rapaport, S.F., Peer, A.D., Viswasam, N., Hahn, E., Ryan, S., Turpin, G., Lyons, C.E., Baral, S. and Hansoti, B., 2023. Implementing HIV prevention in Sub-Saharan Africa: A systematic review of interventions targeting systems, communities, and individuals. *AIDS and Behaviour*, *27*(1), pp.150-160.

Rejeski, W.J. and Fanning, J., 2019. Models and theories of health behaviour and clinical interventions in aging: a contemporary, integrative approach. *Clinical interventions in aging*, pp.1007-1019.

Reniers, G. and Tfaily, R., 2012. Polygyny, partnership concurrency, and HIV transmission in Sub-Saharan Africa. *Demography*, *49*(3), pp.1075-1101.

Reniers, G. and Watkins, S., 2010. Polygyny and the spread of HIV in Sub Saharan Africa: a case of benign concurrency. *AIDS (London, England)*, *24*(2), p.299.

Resnicow, K., Braithwaite, R.L., Dilorio, C. and Glanz, K., 2002. Applying theory to culturally diverse and unique populations. *Health behaviour and health education: Theory, research, and practice*, pp.485-509.

Rettberg, S., Beckmann, G., Minah, M. and Schlechen, A., 2017. Ethiopia's Arid and Semi-Arid Lowlands: Towards Inclusive and Sustainable Rural Transformation: Country Study. Seminar für ländliche Entwicklung (SLE).

Rhonda D.2013. A review of Policy Analysis for Educational Leaders: A Step by Step Approach, by N. A. Alexander, Leadership and Policy in Schools, 12:2, 174-178, DOI: 10.1080/15700763.2013.792936

Rice, R.E. and Atkin, C.K., 2012. Theory and principles of public communication campaigns. *Public communication campaigns*, pp.3-19.

Riley, E.D., Gandhi, M., Bradley Hare, C., Cohen, J. and Hwang, S.W., 2007. Poverty, unstable housing, and HIV infection among women living in the United States. *Current HIV/AIDS Reports*, *4*, pp.181-186.

Rivera, J.D. and Fothergill, A., 2021. Studying vulnerable populations in disaster. *Disaster and emergency management methods: Social science approaches in application*, pp.85-102.

Rebeiro, P.F., McPherson, T.D., Goggins, K.M., Turner, M., Bebawy, S.S., Rogers, W.B., Brinkley-Rubinstein, L., Person, A.K., Sterling, T.R., Kripalani, S. and Pettit, A.C., 2018. Health literacy and demographic disparities in HIV care

Roberts SO, Bareket-Shavit C, Dollins FA, Goldie PD, Mortenson E.2020. Racial Inequality in Psychological continuum outcomes. *AIDS and Behaviour*, *22*, pp.2604-2614.

Robinson, M., Aventin, Á., Hanratty, J., Ruane-McAteer, E., Tomlinson, M., Clarke, M., Okonofua, F. and Lohan, M., 2021. Nothing so practical as theory: a rapid review of the use of behaviour change theory in family planning interventions involving men and boys. *Reproductive Health*, *18*(1), pp.1-26.

Rodgers, C., 2021. Community engagement in pastoralist areas: Lessons from the public dialogue process for a new refugee settlement in Turkana, Kenya. *Pastoralism,11*(1)*,* pp.26.

Rogers, H.L., Hernando, S.P., Núñez-Fernández, S., Sanchez, A., Martos, C., Moreno, M. and Grandes, G., 2021. Barriers and facilitators in the implementation of an evidence-based health promotion intervention in a primary care setting: a qualitative study. *Journal of Health Organization and Management*, *35*(9), pp.349-367.

Rolón-Dow, R. and Bailey, M.J., 2021. Insights on narrative analysis from a study of racial micro aggressions and micro affirmations. *American Journal of Qualitative Research*, *6*(1), pp.1-18.

Roura, M., Nsigaye, R., Nhandi, B. 2010. "Driving the devil away": qualitative insights into miraculous cures for AIDS in a rural Tanzanian ward. BMC Public Health 10, 427. https://doi.org/10.1186/1471-2458-10-427.

Rubin, H.J. and Rubin, I.S., 2011. *Qualitative interviewing: The art of hearing data*. Sage.

Rujumba, J. and Kwiringira, J., 2010. Interface of culture, insecurity and HIV and AIDS: Lessons from displaced communities in Pader District, Northern Uganda. *Conflict and health*, *4*(1), pp.1-10.

Rutherford, G.W., McFarland, W., Spindler, H., White, K., Patel, S.V., Aberle-Grasse, J., Sabin, K., Smith, N., Taché, S., Calleja-Garcia, J.M. and Stoneburner, R.L., 2010. Public health triangulation: approach and application to synthesizing data to understand national and local HIV epidemics. *BMC public health*, *10*(1), pp.1-10.

Ryan, M., & Shackley, P. 1995. Assessing the benefits of health care: how far should we go? Quality in Health Care, 4(3), 207.

Saggurti, N., Mahapatra, B., Swain, S.N. and Jain, A.K., 2011. Male migration and risky sexual behaviour in rural India: is the place of origin critical for HIV prevention programs? *BMC public health*, *11*, pp.1-13.

Saleem, Rozhgar & Othman, Nasih & Fattah, Fattah & Hazim, Luma & Adnan, B. 2013. Female Genital Mutilation in Iraqi Kurdistan: Description and Associated Factors. Women & health. 53. 537-51. 10.1080/03630242.2013.815681.

Salawu, Rafiu & Shamsuddin, Aina Obe & Bolatitio, Shamsuddin & Masibo, Safina. 2023. Theoretical And Conceptual Frameworks In Research: Conceptual Clarification. European Chemical Bulletin. 12. 2103-2117. 10.48047/Ecb/2023.12.12.139.

Sama, M.T. and Nguyen, V.K., 2008. Governing the health system in Africa. *Governing Health Systems in Africa*, pp.3-14.

Sano, Y., Antabe, R., Atuoye, K.N. 2016. Persistent misconceptions about HIV transmission among males and females in Malawi. BMC Int Health Hum Rights 16, 16 (2016). https://doi.org/10.1186/s12914-016-0089-8.

Sayles, J.N., Wong, M.D., Kinsler, J.J., Martins, D. and Cunningham, W.E., 2009. The association of stigma with self-reported access to medical care and antiretroviral therapy adherence in persons living with HIV/AIDS. *Journal of general internal medicine*, *24*, pp.1101-1108.

Scarinci, I.C., Bandura, L., Hidalgo, B. and Cherrington, A., 2012. Development of a theory-based (PEN-3 and health belief model), culturally relevant intervention on cervical cancer prevention among Latina immigrants using intervention mapping. *Health promotion practice*, *13*(1), pp.29-40.

Schiavo, R., May Leung, M. and Brown, M., 2014. Communicating risk and promoting disease mitigation measures in epidemics and emerging disease settings. *Pathogens and Global Health*, *108*(2), pp.76-94.

Schoof, N. and Luick, R., 2018. Pastures and pastoralism. *URL:* http://www*. Oxford bibliographies. Com/display/id/obo-9780199830060-0207 (gesehen am: 26. 5. 2019)*.

Scott, K.D., Gilliam, A. and Braxton, K., 2005. Culturally competent HIV prevention strategies for women of colour in the United States. *Health Care for Women International*, *26*(1), pp.17-45.

Self, Becky. 2021. Conducting interviews during the COVID-19 pandemic and beyond." Forum Qualitative Sozialforschung/Forum: Qualitative Social Research. Vol. 22. No. 3.

Seme, A., Mariam, D.H. and Worku, A., 2005. The association between substance abuse and HIV infection among people visiting HIV counselling and testing centres in Addis Ababa, Ethiopia. Ethiopian *Journal of Health Development*, *19*(2), p.116-125.

Seid, A. and Ahmed, M., 2020. What are the Determinants of Misconception About HIV Transmission Among Ever-Married Women in Ethiopia? *HIV/AIDS-Research and Palliative Care*, pp.441-448.

Serbessa, M.K., 2019. Vulnerability to HIV infection among the Borana pastoral community of Southern Ethiopia: a persisting challenge. *HIV/AIDS-Research and Palliative Care*, pp.69-76.

Serbessa, M.K., Mariam, D.H., Kassa, A., Alwan, F. and Kloos, H., 2016. HIV/AIDS among pastoralists and refugees in north-East Africa: a neglected problem. *African Journal of AIDS research*,*15*(1), pp.45-54.

Seyed Alinaghi S, Karimi A, MohsseniPour M, Barzegary A, Mirghaderi SP, Fakhfouri A, Saeidi S, Razi A, Mojdeganlou H, Tantuoyir MM, Afsahi AM, Mehraeen E, Dadras O.2021. The clinical outcomes of COVID-19 in HIV-positive patients: A systematic review of current evidence. Immun Inflamm Dis.; 9(4):1160-1185. doi: 10.1002/iid3.497.

Sweat MD, Yeh T, Kennedy C, O'Reilly K, Armstrong K, Fonner V. 2019. Condom Social Marketing Effects in Low- and Middle-Income Countries: A Systematic Review Update, 1990 to 2019. American Journal of Health Promotion; 34(1):91-95. doi:10.1177/0890117119864921

Shah, D.V., McLeod, J.M. and Yoon, S.H., 2001. Communication, context, and community: An exploration of print, broadcast, and Internet influences. *Communication research*,*28*(4), pp.464-506.

Shaw, Alison & Sheppard, Stephen & Burch, Sarah & Flanders, David & Wiek, Arnim & Carmichael, Jeff & Robinson, John & Cohen, Stewart. 2009. Making local futures tangible--Synthesizing, downscaling, and visualizing climate change scenarios for participatory capacity building. Global Environmental Change. 19. 447-463. 10.1016/j.gloenvcha.2009.04.002.

Shaw, S.A. and El-Bassel, N., 2014. The influence of religion on sexual HIV risk. *AIDS and Behaviour*, *18*, pp.1569-1594.

Shiferaw, A., Baye, A.M., Amogne, W. and Feyissa, M., 2020. Herbal medicine use and determinant factors among HIV/AIDS patients on antiretroviral therapy in Tikur Anbessa specialized hospital, Addis Ababa, Ethiopia. *HIV/AIDS-Research and Palliative Care*, pp.941-949.

Shih, P., Worth, H., Travaglia, J. and Kelly-Hanku, A., 2017. 'Good culture, bad culture': polygyny, cultural change and structural drivers of HIV in Papua New Guinea. *Culture, Health & Sexuality*,*19*(9), pp.1024-1037.

Shira Maguen, Cohen B, Ren L, Bosch J, Kimerling R, Seal K. 2012. Gender differences in military sexual trauma and mental health diagnoses among Iraq and Afghanistan veterans with posttraumatic stress disorder. Women's Health Issues; 22(1):e61-6.doi: 10.1016/j.whi.2011.07.010. Epub 2011 Sep 9. PMID: 21907590.

Shizha, E. and Charema, J., 2011. Health and wellness in Southern Africa: Incorporating indigenous and western healing practices. *International Journal of Psychology and Counselling*, *3*(9), pp.167-175.

Short, S.E. and Mollborn, S., 2015. Social determinants and health behaviours: conceptual frames and empirical advances. *Current opinion in psychology*, *5*, pp.78-84.

Sia, D., Onadja, Y., Hajizadeh, M., Heymann, S.J., Brewer, T.F. and Nandi, A., 2016. What explains gender inequalities in HIV/AIDS prevalence in sub-Saharan Africa? Evidence from the demographic and health surveys. *BMC public health*, *16*(1), pp.1-18.

Silberschmidt, M., 2001. Disempowerment of men in rural and urban East Africa: implications for male identity and sexual behaviour. *World development*, *29*(4), pp.657-671.

Sileo KM, Fielding-Miller R, Dworkin SL, Fleming PJ.2018. What Role Do Masculine Norms Play in Men's HIV Testing in Sub-Saharan Africa? A Scoping Review. AIDS Behav; 22(8):2468-2479. Doi: 10.1007/s10461-018-2160-z. PMID: 29777420; PMCID: PMC6459015.

Silverman, David. 2006. Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction / D. Silverman.

Singhal, A. and Rogers, E.M. 2003. Combating AIDS: Communication Strategies in Action. Sage Publications, Thousand Oaks.

Singleton, Kate & Krause, Elizabeth. 2009. Understanding Cultural and Linguistic Barriers to Health Literacy. Kentucky nurse. 58. 4, 6-9. 10.3912/OJIN.Vol14No03Man04.

Skovdal, M., Maunzagona, T., Dzamatira, F., Magoge-Mandizvidza, P., Maswera, R., Moyo, B.K., Nyamukapa, C. and Gregson, S., 2023. Condoms are hard to get by: access to HIV prevention methods during lockdown of the COVID-19 epidemic in eastern Zimbabwe. *Global Health Action*, *16*(1), p.2206207.

Smith, R.A., Zhu, X. and Fink, E.L., 2019. Understanding the effects of stigma messages: Danger appraisal and message judgments. *Health Communication*, *34*(4), pp.424-436.

Somma, D.B. and Bodiang, K.C., 2003. The cultural approach to HIV/AIDS prevention. *Social Development Division's Health Desk, Swiss Centre for International Health, Geneva*.

Song, Y. and Qin, Z., 2019. Buddhists care: Examining the impact of religious elements on reducing discriminatory attitudes toward people living with HIV/AIDS.*Religions*,*10*(7), p.409.

Sonja, W. & Christoph, B. 2004. Aids: Meeting the challenge: Data, Facts, Background. World Council of Churches, Geneva, Switzerland.

Sonke J, Pesata V, Nakazibwe V, Ssenyonjo J, Lloyd R, Espino D, Nieves M, Khandakji S, Hahn P, Kerrigan M.2018. The Arts and Health Communication in Uganda: A Light under the Table. Health Commun; 33(4):401-408. Doi: 10.1080/10410236.2016.1266743. Epub 2017 Jan 17. PMID: 28094558.

Sørensen, K., Van den Broucke, S., Fullam, J., Doyle, G., Pelikan, J., Slonska, Z., Brand, H. and (HLS-EU) Consortium Health Literacy Project European, 2012. Health literacy and public health: a systematic review and integration of definitions and models. *BMC public health*,*12*, pp.1-13.

Sovran, S., 2013. Understanding culture and HIV/AIDS in sub-Saharan Africa. *Sahara-J: Journal of Social Aspects of HIV/AIDS*, *10*(1), pp.32-41.

Squire, C., 2013. From experience-centred to socio-culturally-oriented approaches to narrative. *Doing narrative research*, *2*, pp.47-71.

Ssebunya, R.N., Matovu, J.K., Makumbi, F.E., Kisitu, G.P., Maganda, A. and Kekitiinwa, A., 2019. Factors associated with prior engagement in high-risk sexual behaviours among adolescents (10–19 years) in a pastoralist post-conflict community, Karamoja sub-region, North eastern Uganda.*BMC Public Health*,*19*, pp.1-11.

Stake, R.E., 1995. *The art of case study research*. Sage.

Staugård, F. and Anderson, S.V., 1985. Traditional Medicine in Botswana. (*No Title*). Gaborone: Ipelegeng Publishers.

Stewart, G.J., 2014. Contextualization of HIV prevention initiatives in Sub-Saharan Africa, with special reference to gender issues in contexts of human dislocation and migration. *Mission Studies*,*31*(3), pp.377-402.

Storey, D., Seifert-Ahanda, K., Andaluz, A., Tsoi, B., Matsuki, J.M. and Cutler, B., 2014. What is health communication and how does it affect the HIV/AIDS continuum of care? A brief primer and case study from New York City. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, *66*, pp.S241-S249.

Ta'a, T., 2004 The Place of the Oromo in Ethiopian History: 2003 OSA Conference Keynote Address. *Journal of Oromo Studies, 11*(1-2), pp.1-11

Ta'a, T., 2016. The Gadaa system and some of its institutions among the Booranaa: a historical perspective1.*Ethiopian Journal of the Social Sciences and Humanities*,*12*(2), pp.81-97.

Tadesse, G. and Yakob, B., 2015. Risky sexual behaviours among female youth in Tiss Abay, a semi-urban area of the Amhara Region, Ethiopia. *PLOS One*,*10*(3), p.e0119050.

Takele, B., 2020. Analysis of linguistic Taboo Words Related to Sexual Organs and Their Euphemistic Expressions in Oromo. 10.13140/RG.2.2.36077.10723.

Tamiru, M., Hailemariam, D., Mitike, G. and Haidar, J., 2011. HIV-related sexual behaviours among migrants and Non-migrants in rural Ethiopia: role of rural to urban migration in HIV transmission. *International Journal of Biomedical Science: IJBS*,*7*(4), p.295.

Tasah, N.J., 2021. The role of posters written in indigenous languages in disseminating health-awareness information within the far North Region of Cameroon. *European Scientific Journal*,*17*(33), p.181.

Taylor, J.J., 2007. Assisting or compromising intervention? The concept of culture in biomedical and social research on HIV/AIDS. *Social Science & Medicine*, *64*(4), pp.965-975.

Tefera B, Ahmed Y.2013. Contribution of the anti HIV/AIDS community conversation programs in preventing and controlling the spread of HIV/AIDS. Ethiop J Health Dev; 27(3):216–229.

Tefera, S. and Shewadeg, B., 2022. Social protection and the role of actors in pastoral areas of Ethiopia: The missing link between formal and informal systems. In *Social Protection, Pastoralism and Resilience in Ethiopia* (pp. 116-134). Routledge.

Teklehaimanot, H.D., Teklehaimanot, A., Yohannes, M. and Biratu, D., 2016. Factors influencing the uptake of voluntary HIV counselling and testing in rural Ethiopia: a cross sectional study. *BMC public health*, *16*, pp.1-13.

Tenkorang, E.Y., Gyimah, S.O., Maticka-Tyndale, E. and Adjei, J., 2011. Superstition, witchcraft and HIV prevention in sub-Saharan Africa: the case of Ghana. *Culture, health & sexuality*,*13*(9), pp.1001-1014.

Tesha, J., Fabian, A., Mkuwa, S., Misungwi, G. and Ngalesoni, F., 2023. The role of gender inequities in women's access to reproductive health services: a population-level study of Simiyu Region Tanzania. *BMC Public Health*, *23*(1), pp.1-9.

Teshale, A.B. and Tesema, G.A., 2023. Socioeconomic Inequality in Knowledge About HIV and Its Contributing Factors Among Women of Reproductive Age in Sub-Saharan

Africa: A Multicounty and Decomposition Analysis. *HIV/AIDS-Research and Palliative Care*, pp.53-62.

Thiabaud, A., Triulzi, I., Orel, E., Tal, K. and Keiser, O., 2020. Social, behavioural, and cultural factors of HIV in Malawi: semi-automated systematic review. *Journal of medical internet research*,*22*(8), p. e18747.

Timmins F. 2002. The usefulness of learning contracts in nurse education: the Irish perspective. Nurse Educ Pract; 2(3):190-6. Doi: 10.1054/nepr.2002.0069. PMID: 19036297.

Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, Moher D, Peters MDJ, Horsley T, Weeks L, Hempel S, Akl EA, Chang C, McGowan J, Stewart L, Hartling L, Aldcroft A, Wilson MG, Garritty C, Lewin S, Godfrey CM, Macdonald MT, Langlois EV, Soares-Weiser K, Moriarty J, Clifford T, Tunçalp Ö, Straus SE. 2018. PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. Ann Intern Med.; 169(7):467-473. doi: 10.7326/M18-0850. Epub 2018 Sep 4. PMID: 30178033.

Thompson, Judy, Yolanda Havenga, and Susan N.2015. "The health literacy needs of women living with HIV/AIDS." Health SA Gesondheid 20.1: 11-21.

Thornton, R., 2009. Sexual networks and social capital: multiple and concurrent sexual partnerships as a rational response to unstable social networks. *African Journal of AIDS Research*,*8*(4), pp.413-421.

Thorp, M., Ayieko, J., Hoffman, R.M., Balakasi, K., Camlin, C.S. and Dovel, K., 2023. Mobility and HIV care engagement: a research agenda. *Journal of the International AIDS Society*, *26*(3), p.e26058.

Tofu, D.A., Fana, C., Dilbato, T., Dirbaba, N.B. and Tesso, G., 2023. Pastoralists' and agro-pastoralists' livelihood resilience to climate change-induced risks in the Borana zone, south Ethiopia: Using resilience index measurement approach. *Pastoralism*,*13*(1), p.4.

Tomaselli, K., 2011. Introduction: Paradigm interaction: Some notes on development and communication. *Development and Public Health Communication, Cape Town: Pearson Education*, pp.1-11.

Tomori, C., Risher, K., Limaye, R.J., Van Lith, L.M., Gibbs, S., Smelyanskaya, M. andCelentano, D.D., 2014. A role for health communication in the continuum of HIV care, treatment, and prevention. *JAIDS Journal of Acquired Immune Deficiency Syndromes, 66*, pp.S306-S310.

Touriño, Rafael & Acosta, Francisco & Giráldez, Alba & Álvarez, Jorge & González, Jesús & Abelleira, Cristina & Benítez, Natalia & Baena, Ernesto & Fernandez, Jaime & Rodriguez, C.2018. Suicidal risk, hopelessness and depression in patients with schizophrenia and internalized stigma. Actas espanolas de psiquiatria. 46. 33-41.

Treweek, S., Pitkethly, M., Cook, J., Fraser, C., Mitchell, E., Sullivan, F., Jackson, C., Taskila, T.K. and Gardner, H., 2018. Strategies to improve recruitment to randomized trials. *Cochrane database of systematic reviews*, (2).

Trinitapoli, J., 2009. Religious teachings and influences on the ABCs of HIV prevention in Malawi. *Social science & medicine*,*69*(2), pp.199-209.

Trinitapoli, J. and Regnerus, M.D., 2006. Religion and HIV risk behaviours among married men: Initial results from a study in rural Sub-Saharan Africa. *Journal for the scientific study of religion*,*45*(4), pp.505-528.

Truebswasser, U. and Flintan, F.E., 2018. Extensive (pastoralist) cattle contributions to food and nutrition security.

Tsvere, M., 2022.How would you align the research problem, objective and questions? https://www.researchgate.net/post/How_would_you_allign_the_research_problem_objective_and_questions/6296b46a545a136eda2c47d8/citation/download.

Tufte, T. and Mefalopulos, P., 2009.*Participatory communication: A practical guide* (Vol. 170). World Bank Publications.

Tumwine, C., Aggleton, P. and Bell, S., 2019. Accessing HIV treatment and care services in fishing communities around Lake Victoria in Uganda: mobility and transport challenges. *African Journal of AIDS Research*, *18*(3), pp.205-214.

United States Department of Health and Human Services (DHHS). 2013. The HIV/AIDS Continuum of Care. Washington, DC.

UN, 2015. The Millennium Development Goals Report.

UN 2010, Food assistance needs in Ethiopia rising for 2010, UN relief wing reports. UN News Service

UN OCHA. 2017. Enhancing Pastoral Women's Economic Empowerment in Lowland Borena, Dire and Miyo Districts, Borena Zone, Oromia Regional State

UN OCHA-Ethiopia, 2004. Focus on Ethiopia. United Nations Office for the Coordination of Humanitarian Affairs.

UNAIDS. 2022. Global AIDS Update, Geneva: Joint United Nations Program on HIV/AIDS. *Licence*: CC BY-NC-SA 3.0 IGO.

UNAIDS. 2022. IN DANGER: Global AIDS Update. Geneva: Joint United Nations Programme on HIV/AIDS. Licence: Geneva, Switzerland.

UNAIDS, 2020. Seizing the moment: tackling entrenched inequalities to end epidemics. *Global AIDS Update*.

UNAIDS. 2018. Fast-Track – Ending the AIDS Epidemic by 2030.

UNAIDS.2018. Gender Action Plan 2018–2023: A framework for accountability.

UNAIDS. 2016. Ending AIDS: Progress towards the 90-90-90 Targets.

UNAIDS. 2013. Global report on the global AIDS epidemic. Geneva: Switzerland.

UNAIDS. 2011. Letter to the Partners. Geneva, Switzerland.

UNAIDS. 2010. AIDS Global report: UNAIDS report on the global AIDS epidemic. Geneva, Switzerland.

UNAIDS. 2010. AIDS Global report: UNAIDS report on the global AIDS epidemic. Geneva, Switzerland.

UNAIDS. 2009. AIDS epidemic update. Geneva: Switzerland.

UNAIDS. 2008. UNAIDS report on the global HIV/AIDS. Geneva: Switzerland.

UNAIDS. 2007. Safe, voluntary, informed male circumcision and comprehensive HIV Prevention programming: Guidance for decision makers on human rights, ethical and legal consideration. Geneva, Switzerland. Geneva, Switzerland.

UNAIDS. 2006. Collaborating with Traditional Healers for HIV Prevention and Care in sub-Saharan Africa: suggestions for Programme Managers and Field Workers.

UNAIDS. 2004. AIDS and Culture. Geneva, Switzerland.

UNAIDS. 2004a. Report on the global AIDS epidemic. Geneva, Switzerland.

UNAIDS. 2002. What Happened in Uganda? Declining HIV Prevalence, Behaviour Change, and the National Response.

UNAIDS.2001. HIV/AIDS and communication for behaviour and social change: programme experiences, examples, and way forward. Geneva: Switzerland.

UNAIDS. 2000. A Cultural Approach to HIV/AIDS Prevention and Care: Summary of Country Assessments and Project Design Handbook. Paris: UNESCO.

UNAIDS, U. and World Health Organization, 2011. Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011. *Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011.*

UNDESA .2018. *World Urbanization Prospects: The 2018 Revision, Online Edition.*, United Nations, Department of Economic and Social Affairs, Population Division, https://www.un.org/development/desa/publications/.

UNESCO.2001. Universal Declaration on Cultural Diversity: Adopted by the General Conference of the United Nations Educational, Scientific and Cultural Organization. Paris, France.

UNICEF (United Nations Children's Fund). 2014. Educations and resilience in Kenya's arid lands. Nairobi.

UNFPA. 2002. 'Communication for Development'. Roundtable Report. Focus on HIV/AIDS Communication and Evaluation, UNFPA, New York.

UNDP, A., 2016. *Africa Human Development Report 2016: Accelerating Gender Equality and Women's Empowerment in Africa* (No. 267638). United Nations Development Programme.

USAID. 2018. HIV and AIDS in East and Southern Africa regional overview [Internet]. Avert.

USAID.2016. Prevention gap report

USAID. 2016. Resilience at USAID 2016 progress report. Washington, DC: USAID. Center for Resilience.

Usadolo, S.E., 2019. Christians' perceptions of HIV prevention in Benin City, Nigeria: Implications for HIV/AIDS communication. *Cogent Medicine*, *6*(1), p.1658957.

Usonwu, I., Ahmad, R. and Curtis-Tyler, K., 2021. Parent–adolescent communication on adolescent sexual and reproductive health in sub-Saharan Africa: a qualitative review and thematic synthesis. *Reproductive Health*,*18*(1), pp.1-15.

Usonwu, I., Ahmad, R. & Curtis-Tyler, K.2021. Parent–adolescent communication on adolescent sexual and reproductive health in sub-Saharan Africa: a qualitative review and thematic synthesis. Reprod Health 18, 202. https://doi.org/10.1186/s12978-021-01246-0.

Uusküla, A., Vickerman, P., Raag, M., Walker, J., Paraskevis, D., Eritsyan, K., Sypsa, V., Lioznov, D., Avi, R. and Des Jarlais, D., 2020. Presenting a conceptual framework for an HIV prevention and care continuum and assessing the feasibility of empirical measurement in Estonia: A case study. *PLOSOne*, *15*(10), p.e0240224.

Uwah, C., 2019. Indigenous belief systems and HIV/AIDS in South Africa: examining HIV/AIDS communication from a cultural psychological perspective. *Gender and Behaviour*,*17*(4), pp.14026-14037.

Uwah, C., 2013. The role of culture in effective HIV/AIDS communication by theatre in South Africa. *SAHARA-J: Journal of Social Aspects of HIV/AIDS*, *10*(3-4), pp.140-149.

Valente, Thomas & Bharath, U. 1999. An evaluation of the use of drama to communicate HIV/AIDS information. AIDS education and prevention: official publication of the International Society for AIDS Education. 11. 203-11.

Van Belle, S.B., Marchal, B., Dubourg, D. and Kegels, G., 2010. How to develop a theory-driven evaluation design? Lessons learned from an adolescent sexual and reproductive health programme in West Africa. *BMC public health*, *10*(1), pp.1-10.

Van den Hoonaard, W.C., 2003. Is anonymity an artefact in ethnographic research? *Journal of academic Ethics*, *1*, pp.141-151.

Vandepitte J, Lyerla R, Dallabetta G, Crabbé F, Alary M, Buvé A. 2006. Estimates of the number of female sex workers in different regions of the world. Sex Transm Infect; 82

Suppl 3 (Suppl 3): iii18-25. Doi: 10.1136/sti.2006.020081. PMID: 16735288; PMCID: PMC2576726.

Van der Kwaak, A., Baltissen, G., Nduba, J., van Beek, W., Ferris, K. and Plummer, D., 2012. Sexual and reproductive health of nomadic peoples in East Africa.

Van Olmen, J., Schellevis, F., Van Damme, W., Kegels, G., & Rasschaert, F. 2012. Management of chronic diseases in sub-Saharan Africa: cross-fertilisation between HIV/AIDS and diabetes care. Journal of tropical medicine.

Van Servellen, G., 2009. *Communication skills for the health care professional: Concepts, practice, and evidence*. Jones & Bartlett Publishers.

Van Staden, A. and Badenhorst, G., 2009. Reviewing gender and cultural factors associated with HIV/AIDS among university students in the South African context. *Curationis*,*32*(4), pp.19-28.

Vermund, S.H., Mallalieu, E.C., Van Lith, L.M. and Struthers, H.E., 2017. Health communication and the HIV continuum of care. *Journal of Acquired Immune Deficiency Syndromes (1999)*, *74*(Suppl 1), p.S1.

Vermund, S.H., Van Lith, L.M. and Holtgrave, D., 2014. Strategic roles for health communication in combination HIV prevention and care programs. *AIDS Journal of Acquired Immune Deficiency Syndromes*,*66*, pp.S237-S240.

Vermund, S.H. and Hayes, R.J., 2013. Combination prevention: new hope for stopping the epidemic. *Current HIV/AIDS Reports*,*10*, pp.169-186.

Vigliotti, V., Taggart, T., Walker, M., Kusmastuti, S. and Ransome, Y., 2020. Religion, faith, and spirituality influences on HIV prevention activities: A scoping review. *PloS one*, *15*(6), p.e0234720.

Viswasam, N., Schwartz, S. and Baral, S., 2020. Characterizing the role of intersecting stigmas and sustained inequities in driving HIV syndemics across low-and middle-income settings. *Current Opinion in HIV and AIDS*,*15*(4), p.243.

Vitsupakorn, S., Pierce, N. and Ritchwood, T.D., 2023. Cultural interventions addressing disparities in the HIV prevention and treatment cascade among Black/African Americans: a scoping review. *BMC Public Health*,*23*(1), p.1748.

Wakefield, M.A., Loken, B. and Hornik, R.C., 2010. Use of mass media campaigns to change health behaviour. *The lancet*, *376*(9748), pp.1261-1271.

Wakuma, C. and Teresa, E., 2020. Language as a Barrier to Health Care for Oromo Speaking Patients in Hospitals: A Case Study on Jimma and Wollega Public Hospitals. *International Journal of Multicultural and Multireligious Understanding*,*6*(6), pp.693-711.

Wallerstein, N. and Duran, B., 2010. Community-based participatory research contributions to intervention research: the intersection of science and practice to improve health equity. *American journal of public health*, *100*(S1), pp.S40-S46.

Wanyoike, P.N., 2011. *The perceptions of rural Samburu women in Kenya with regard to HIV/AIDS: Towards developing a communication strategy* (Doctoral dissertation, University of South Africa).

Wangui, E.E., 2008. Development interventions, changing livelihoods, and the making of female Maasai pastoralists. *Agriculture and Human Values*,*25*, pp.365-378.

Waldrop-Valverde, D., Osborn, C.Y., Rodriguez, A., Rothman, R.L., Kumar, M. and Jones, D.L., 2010. Numeracy skills explain racial differences in HIV medication management. *AIDS and Behavior*,*14*, pp.799-806.

Walker, K.L., Hart, J.L. and D'Silva, M.U. eds., 2012. *Communicating about HIV/AIDS: Taboo Topics and Forbidden Conversations*. Hampton Press.

Warkineh, T.Z. and Gizaw, A.M., 2019. Exploring the informal learning experiences of women in a pastoral community in Ethiopia: The case of pastoral women in Karrayyu. *Studies in the Education of Adults*, *51*(2), pp.250-267.

Wassie, S.M., Aragie, L.L., Taye, B.W. and Mekonnen, L.B., 2015. Knowledge, attitude, and utilization of traditional medicine among the communities of Merawi town, Northwest Ethiopia: a cross-sectional study. *Evidence-based complementary and alternative medicine*, *2015*.

Waters-Bayer, A., Birmeji, B. and Mengistu, G., 2005, March. Ethiopian pastoralists and HIV/AIDS: Few facts, many fears and a glimmer of hope. In*FAO Technical Workshop Linkages between HIV/AIDS and the Livestock Sector in Eastern and Southern Africa*.

Watson, M.D., 2014. Apartheid in their hearts? How the South African critique of individualism is probably right. *Howard Journal of Communications*,*25*(2), pp.134-155.

Weinreich, S. and Benn, C., 2004.*AIDS-meeting the challenge: data, facts, background*. WCC Publication

Weinstein, N.D., Rothman, A.J. and Sutton, S.R., 1998. Stage theories of health behaviour: conceptual and methodological issues. *Health psychology*, *17*(3), p.290.

Weinstein, N.D. and Sandman, P.M., 2002. Chapter two: the precaution adoption process model and its application. *Emerging theories in health promotion practice and research: strategies for improving public health. San Francisco, CA, USA: Jossey-Bass*, pp.16-39.

Weston, D., Ip, A. and Amlôt, R., 2020. Examining the application of behaviour change theories in the context of infectious disease outbreaks and emergency response: a review of reviews *public health*,*20*(1), pp.1-19.

Whitehead, T.L., 1997. Urban low-income African American men, HIV/AIDS, and gender identity. *Medical Anthropology Quarterly*,*11*(4), pp.411-447.

Whitelaw, S. and Clark, D., 2019. Palliative care and public health: an asymmetrical relationship? *Palliative Care: Research and Treatment*,*12*, p.1178224218819745.

Willems, R., 2009. The importance of interdisciplinary collaborative research in responding to HIV/AIDS vulnerability in rural Senegal. *African Journal of AIDS Research*,*8*(4), pp.433-442.

Williams, J.K., Wyatt, G.E. and Wingood, G., 2010. The four Cs of HIV prevention with African Americans: crisis, condoms, culture, and community. *Current HIV/AIDS Reports*,*7*, pp.185-193.

Williams, D.R. and Sternthal, M., 2010. Understanding racial-ethnic disparities in health: sociological contributions. *Journal of health and social behaviour*, *51*(1_suppl), pp.S15-S27.

Wilson, D. and Taaffe, J., 2017. Tailoring the local HIV/AIDS response to local HIV/AIDS epidemics. *Major Infectious Diseases. 3rd edition*.

Wilson, F.L., Racine, E., Tekieli, V. and Williams, B., 2003. Literacy, readability and cultural barriers: critical factors to consider when educating older African Americans about anticoagulation therapy. *Journal of clinical nursing*,*12*(2), pp.275-282.

Wilson, B.D. and Miller, R.L., 2003. Examining strategies for culturally grounded HIV prevention: A review. *AIDS Education and Prevention*,*15*(2), pp.184-202.

Wondmeneh, T.G. and Wondmeneh, R.G., 2023. Risky Sexual Behaviour among HIV-Infected Adults in Sub-Saharan Africa: A Systematic Review and Meta-Analysis. *BioMed Research International*,*2023*.

World Bank. 2000. Project Appraisal Document. Rept. No. 20727AFR. Washington, D.C.

World Council of Churches. 2001. Statement by Faith-based Organisations facilitated by the World Council of Churches for the UN Special General Assembly on HIV/AIDS. *International Review of Mission*, 90(359): 473-6.

World Health Organization. 2023. HIV and AIDS. Google Scholar.

WHO.2022. Using Recency Assays for HIV Surveillance: Technical Guidance. World Health Organization.

World Health Organization, 2018. World health statistics 2016: Monitoring health for the SDGs, sustainable development goals (World Health Organization, Geneva). World Health Organization, 2018. HIV/AIDS surveillance in Europe 2018: 2017 data. World Health Organization, 2017.*Communicating risk in public health emergencies: a WHO guideline for emergency risk communication (ERC) policy and practice*.

World Health Organization (WHO). 2011. Planning Guide for the Health Sector Response to HIV/AIDS. Geneva.

World Health Organization. World Health Organization, 2011. Preventing HIV among sex workers in sub-Saharan Africa: a literature review.

WHO. 2016. A tool for strengthening gender-sensitive national HIV and Sexual and Reproductive Health (SRH) monitoring and evaluation systems. World Health Organization.

WHO. 2013. HIV/AIDS: A Strategy for the Who African Region. WHO Regional Office for Africa.

WHO. 2010. Delivered by Women, Led By Men: A Gender and Equity Analysis of the Global Health and Social Workforce Human Resources for Health Observer Series No. 24.

WHO. 2009. AIDS epidemic update. Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization.

World Health Organization, 1995. Supportive environments for health: Sundsvall statement (No. WHO/HPR/HEP/95.3. Unpublished). World Health Organization.

Wolf, M.S., Davis, T.C., Tilson, H.H., Bass III, P.F. and Parker, R.M., 2006. Misunderstanding of prescription drug warning labels among patients with low literacy. *American Journal of Health-System Pharmacy*,*63*(11), pp.1048-1055.

Workneh, T., Emirie, G., Kaba, M., Mekonnen, Y. and Kloos, H., 2018. Perceptions of health and illness among the Konso people of south-western Ethiopia: persistence and change. *Journal of ethno-biology and ethnomedicine*,*14*(1), pp.1-9.

Woźniak, W., 2014. Homogeneity of focus groups as a pathway to successful research findings? *PrzeglądSocjologiiJakościowej*,*10*(1), pp.6-23.

Wyatt, G.E., Williams, J.K., Gupta, A. and Malebranche, D., 2012. Are cultural values and beliefs included in US based HIV interventions? *Preventive Medicine*,*55*(5), pp.362-370.

Yang, F., Janamnuaysook, R., Boyd, M.A., Phanuphak, N. and Tucker, J.D., 2020. Key populations and power: people-centred social innovation in Asian HIV services.*The Lancet HIV*,*7*(1), pp.e69-e74.

Yeboah, Isaac & Okyere, Joshua & Dey, Nutifafa & Mensah, Ronald & Agbadi, Pascal & Essiaw, M. 2022. Multiple sexual partnership among adolescent boys and young men in Ghana: analysis of the 2003-2014 Ghana Demographic and Health Survey. Tropical Medicine and Health. 10.1186/s41182-022-00484-7.

Yeo, J., Knox, C.C. & Jung, K.2018. Unveiling cultures in emergency response communication networks on social media: following the 2016 Louisiana floods. Qual Quant 52, 519–535. https://doi.org/10.1007/s11135-017-0595-3.

Yin, R.K., 2009.*Case study research: Design and methods* (Vol. 5). sage.

Yitbarek, S., Wogasso, Y., Meagher, M. and Strickland, L., 2022. Life Skills Education in Ethiopia: Afar Pastoralists' Perspectives. *Life Skills Education for Youth*, p.245.

Yoshida, I., Kobayashi, T., Sapkota, S. and Akkhavong, K., 2012. Evaluating educational media using traditional folk songs ('lam') in Laos: a health message combined with oral tradition. *Health promotion international*,*27*(1), pp.52-62.

Zena Berhanu M. 2010. Holy Water as an Intervention for HIV/AIDS in Ethiopia, Journal of HIV/AIDS & Social Services, 9:3, 240-260, DOI: 10.1080/15381501.2010.502802.

Zepro, N.B., Ali, N.T., Tarr, N., Medhanyie, A.A., Paris, D.H., Probst-Hensch, N. and Merten, S., 2023. Sexual and reproductive health services use among adolescents in pastoralist settings, north-eastern Ethiopia. *BMC Health Services Research*,*23*(1), pp.1-13.

Zhang, M., Zhu, B., Yuan, C., Zhao, C., Wang, J., Ruan, Q., Han, C., Bao, Z., Chen, J., Arceneaux, K.V. and Wielen, R.V., 2021. Are need for affect and cognition culture dependent? Implications for global public health campaigns: a cross-sectional study. *BMC public health*,*21*, pp.1-14.

Zhao, X., 2020. Health communication campaigns: A brief introduction and call for dialogue. *International Journal of Nursing Sciences*,*7*, pp.S11-S15.

Zimmerman, F.J., Christakis, D.A. and Meltzoff, A.N., 2007. Associations between media viewing and language development in children under age 2 years. *The Journal of pediatrics*,*151*(4), pp.364-368.

Zou, J., Yamanaka, Y., John, M., Watt, M., Ostermann, J. and Thielman, N., 2009. Religion and HIV in Tanzania: influence of religious beliefs on HIV stigma, disclosure, and treatment attitudes. *BMC public health*,*9*, pp.1-12.

Zuma, T., Wight, D., Rochat, T. and Moshabela, M., 2018. Navigating multiple sources of healing in the context of HIV/AIDS and wide availability of antiretroviral treatment: a qualitative study of community participants' perceptions and experiences in rural South Africa. *Frontiers in public health*,*6*, p.73.

APPENDIX A: LETTER OF APPROVAL FROM ARERO DISTRICT, BORANA ZONE, ADMINISTRATIVE OFFICE

Ref: 03/A11/163/1

Date: 20/10/2019

To: College of Human Sciences, University of South Africa (UNISA)

Subject: Giving Letter of Consent

Mr. DANO ENDALU OLANA (OLANA D E) requested Arero district, Borana Zone, to get a letter of consent to undertake his PhD study on the title" **An assessment of the cultural appropriateness in communicating HIV and AIDS messages among Borana pastoralist community in Borana, Ethiopia.**" The researcher is looking for research participants in our district who are well informed about Borana culture, have exposure to HIV/AIDS communication in the district and have lived experience with regard to the day to day lives of the pastoralist community. The researcher also points out in detail the research topic, objectives, purpose, nature, scope, method, and intent of the study in the participant consent form. The district also ensures that the research participants are willing to give oral consent during the data collection.

Therefore, our district kindly informs your college and the respective UNISA board of examiners that Mr. DANO ENDALU OLANA (OLANA D E) is allowed to conduct his PhD project in Arero district pastoralist community, Borana Zone, Oromia.

With best regards,

Abyoo Dido Guyyo

Bulchaa Aanaa Arero

Arero Woreda Administrato

CC

- Mr. Dano Endalu Olana

  Arero district

APPENDIX B: LETTER OF APPROVAL FROM UNISA, COLLEGE OF HUMAN SCIENCES RESEARCH REVIEW ETHICS COMMITTEE

UNISA

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

04 March 2020

Dear DANO ENDALU OLANA

DIS Registration #:REC 240616-052

CREC References #: 2020-CHS-57651299

Student #: 57651299

Decision:

Ethics Approval from 01 March 2020 till 31 February 2024

Researcher(s): DANO ENDALU OLANA

Supervisor(s): DR C.P. CILLIERS
Email: cillicp@unisa.ac.za
Tel: Tel: 012 429 6282

An Assessment Of The Cultural Appropriateness In Communicating Hiv/Aids Messages Among The Rural Pastoralist Borana Community In Borana, Ethiopia

Qualifications Applied: Doctoral Study

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

Thank you for the application for research ethics clearance by the College of Human Science Research Ethics Committee for the above-mentioned research. Ethics approval is granted for

The ***Medium risk application*** was reviewed and expedited by the Research Ethics Committee on 18 Jan 2020 in compliance with the Unisa Policy on Research Ethics and the Standards Operating Procedure on Research Ethics Risk Assessment. The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy of Research Ethics.
2. Any adverse circumstances arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the Department of Information Science Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards the protection of participants' privacy and the confidentiality of the data should be reported to the Committee in writing, accompanied by a progress report.
5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no. 4 of 2013; Children's Act no. 38 of 2005 and the National Health Act, no. 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data requires additional ethics clearance.
7. No field work activities may continue after the expiry date of **31 February 2024.** Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

The reference number 2020-CREC-57651299 should be clearly indicated on all forms of communication with the intended research participants, as well as the Committee.

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

Yours sincerely

Dr Elijah Ngoweni Duba

CREC Chairperson

Tel: 012 429 3892

E-mail:

APPENDIX C: IN-DEPTH INTERVIEW QUESTIONING ROUTE: CULTURAL LEADERS

PART ONE

IN-DEPTH INTERVIEW REGISTRATION FORM

Pseudonym			
In-depth interview number			
Date of in-depth interview			
Time of in-depth interview		to	
Tape number			
Location of in-depth interview			
Moderator's name			
Moderator's phone number			
Assistant moderator's name			
Assistant moderator's phone number			

BIOGRAPHICAL INFORMATION

S/N	
Pseudonym	
Sex	
Marital status	
Age	
Religion	
Education	
Administrative district	
Administrative *kebele*	
Responsibility	
Phone number	

PART TWO

IN-DEPTH INTERVIEW QUESTIONING ROUTE

1. Cultural embedment in HIV/AIDS communication

S/N	Questioning route	Summary/ Key points	Notable quotes
1.1	Explain HIV/AIDS as an illness?		
1.2	What is your view on the role of communication to prevent HIV/AIDS?		
1.3	What is your view on the integration of HIV/AIDS communication into the culture of this community?		
1.4	What is your view on the language appropriateness of HIV/AIDS communication?		
1.5	What is your view on the integration of Borana values and norms into the HIV/AIDS communication?		
1.6	Tell me about your role in designing HIV/AIDS messages.		
1.7	Tell me about the role of cultural resources such as: 1.7.1 Borana proverbs 1.7.2 Familiar tales 1.7.3 Familiar fables 1.7.4 Borana cultural songs 1.7.5 Borana cultural dances 1.7.6 Borana cultural drama		
1.8	Tell me about the role of the cultural institutions/associations such as: 1.8.1 "*Gadaa*" 1.8.2 "Qaalluu" 1.8.3 "*GumiiGaayyoo*" 1.8.4 "*Daboo*" 1.8.5 "*Afoosha*"		
1.9	Explain the cooperation between cultural leaders and health professionals to communicate		

	HIV/AIDS messages.		
1.10	Explain the cultural practices that instigate the spread of HIV/AIDS in this community.		
1.11	Explain the cultural resources in this community that are used to tackle HIV/AIDS.		
1.12	What is your opinion on the cultural remedies to cure HIV/AIDS?		
1.13	What is your suggestion to integrate HIV/AIDS communication into the socio-cultural contexts of this community?		

2 Gender orientation in HIV/AIDS communication

S/N	Questioning route	Summary/ Key points	Notable quotes
2.1	What is your view on the relationship between gender and HIV/AIDS?		
2.2	What is your view on HIV/AIDS communication regarding gender differences?		
2.3	In your opinion, do men and women have equal opportunities to participate in the HIV /AIDS campaigns in your community?		
2.4	Explain gender roles in terms of addressing HIV/AIDS messages in your community.		
2.5	How do you suggest HIV/AIDS communication should be framed in terms of gender?		

3. Behavioural change in reaction to HIV/AIDS communication

S/N	Questioning route	Summary/ Key points	Notable quotes
3.1	Explain the behavioural changes in your community because of HIV/AIDS communication.		
3.2	Explain your role in preventing the spread of HIV/AIDS.		
3.3	How do you view the collective actions in your community to prevent the spread of HIV/AIDS?		

3.4	What is your view on HIV/AIDS communication in your community? Is the focus on individual or social behavioural change?		
3.5	What is your view on HIV/AIDS communication strategies in contributing to behavioural change?		
3.6	Explain the external factors that affect behavioural change regarding HIV/AIDS.		
3.7	Which health behaviour change do you suggest to bring about change in terms of HIV/AIDS?		

4. HIV/AIDS communication approach

S/N	Questioning route	Summary/ Key points	Notable quotes
4.1	Explain HIV/AIDS communication approaches in your community.		
4.2	What is your view on the familiarity of the HIV/AIDS communication approaches to the socio-cultural contexts of this community?		
4.3	What is your view about HIV/AIDS communication channels in the socio-cultural contexts of this community?		
4.4	Explain your role in choosing suitable HIV/AIDS communication approaches for your community.		
4.5	What is your view of the participatory nature of HIV/AIDS communication approaches in this community?		
4.6	Explain the gap you observe in the HIV/AIDS communication approaches.		
4.7	What is your view on how the HIV/AIDS communication approaches consider the differences among the community members?		
4.8	Which HIV/AIDS communication approaches do you suggest for this community?		
4.9	On question 4.8, could you explain the reason for suggesting the HIV/AIDS communication		

	approaches for this community?		

5. Religious/Spiritual perspectives of HIV/AIDS communication approach

S/N	Questioning route	Summary/ Key points	Notable quotes
5.1	Explain HIV/AIDS as an illness.		
5.2	What is your view on HIV/AIDS from a religious/spiritual perspective?		
5.3	How do you view the role of communication to prevent HIV/AIDS in this community?		
5.4	How do you view the integration of HIV/AIDS communication to the religious values and norms of this community?		
5.5	Explain your role in HIV/AIDS message communicating.		
5.6	What is your view on the role of the below Borana cultural resources in HIV/AIDS communication: 4.6.1 Borana proverbs 4.6.2 Familiar tales 4.6.3 Familiar fables 4.6.4 Borana cultural songs 4.6.5 Borana cultural dances 4.6.6 Borana cultural drama		
5.7	Explain the role of religious institutions to communicate the HIV/AIDS message.		
5.8	How do you view the cooperation between religious leaders and other stakeholders to tackle HIV/AIDS problems in this community?		
5.9	Explain the religious beliefs that contribute to the spread of HIV/AIDS.		
5.10	What do you suggest to promote HIV/AIDS communication in this community?		

APPENDIX D: IN-DEPTH INTERVIEW QUESTIONING ROUTE: RELIGIOUS LEADERS

PART ONE

IN-DEPTH INTERVIEW REGISTRATION FORM

Pseudonym			
In-depth interview number			
Date of in-depth interview			
Time of in-depth interview		to	
Tape number			
Location of in-depth interview			
Moderator's name			
Moderator's phone number			
Assistant moderator's name			
Assistant moderator's phone number			

BIOGRAPHICAL INFORMATION

S/N	
Pseudonym	
Sex	
Marital status	
Age	
Religion	
Education	
Administrative district	
Administrative *kebele*	
Responsibility	
Phone number	

PART TWO

IN-DEPTH INTERVIEW QUESTIONING ROUTE

1. Religious/spiritual orientation in HIV/AIDS communication

S/N	Questioning route	Summary/ Key points	Notable quotes
2.1	What is your view on HIV/AIDS from a gender perspective?		
2.2	How do you view gender equality in terms of accessing HIV/AIDS information in this community?		
2.3	Explain the role of religious institutions to support gender-oriented HIV/AIDS campaigns.		
2.4	Explain the positive gender perceptions that support HIV/AIDS campaigns in this community.		
2.5	Explain the gender perceptions that spread HIV/AIDS in this community.		
2.6	What do you suggest to promote gender relevant HIV/AIDS communication?		

2. Behavioural change in relation to HIV/AIDS communication

S/N	Questioning route	Summary/ Key points	Notable quotes
3.1	How do you view the behavioural change in this community regarding HIV/AIDS?		
3.2	Explain the role of religious/spiritual institutions to bring behavioural change in terms of HIV/AIDS.		
3.3	Do you think HIV/AIDS communication in your community focuses on individual or social behavioural change?		
3.4	Explain the religious/spiritual values for positive behavioural change about HIV/AIDS.		
3.5	What do you suggest to bring about positive behavioural change regarding HIV/AIDS?		

3. HIV/AIDS communication approach

S/N	Questioning route	Summary/ Key points	Notable quotes
4.1	How do you view the familiarity of HIV/AIDS communication approaches to the contexts of this community?		
4.2	Do you think HIV/AIDS communication channels consider the spiritual/religious contexts?		
4.3	How do you view the participatory nature of HIV/AIDS communication approaches?		
4.4	Explain the gaps in the HIV/AIDS communication approaches.		
4.5	Do you think HIV/AIDS communication approaches consider the below aspects of the community? 4.5.1 Language 4.5.2 Religion 4.5.3 Gender 4.5.4 Education 4.5.5 Age 4.5.6 Environment 4.5.7 Work nature 4.5.8 Media exposure		
4.7	What kind of HIV/AIDS communication approaches do you suggest for this community?		

APPENDIX E: IN-DEPTH INTERVIEW QUESTIONING ROUTE: HEALTHCARE WORKERS

PART ONE: IN-DEPTH INTERVIEW REGISTRATION FORM

Pseudonym			
In-depth interview number			
Date of in-depth interview			
Time of in-depth interview		to	
Tape number			
Location of in-depth interview			
Moderator's name			
Moderator's phone number			
Assistant moderator's name			
Assistant moderator's phone number			

BIOGRAPHICAL INFORMATION

S/N	
Pseudonym	
Sex	
Marital status	
Age	
Religion	
Education	
Administrative district	
Administrative *kebele*	
Responsibility	
Phone number	

PART TWO: IN-DEPTH INTERVIEW SEMI-STRUCTURED QUESTIONING ROUTE

1. Cultural embedment in HIV/AIDS communication

S/N	Questioning route	Summary/ Key points	Notable quotes
1.1	What is your view on the health behaviour of this community?		
1.2	What is your view on HIV/AIDS problems in this community?		
1.3	Tell me about the organisations working on HIV/AIDS in this district.		
1.4	Tell me about the role of communication for HIV/AIDS.		
1.5	What is your view on the integration of HIV/AIDS communication into the cultural contexts of this community?		
1.6	What is your view on language clarity to address HIV/AIDS issues?		
1.7	What is your role in designing HIV/AIDS messages for this community?		
1.8	What is your view on the use of Borana cultural resources, such as the below, with reference to HIV/AIDS communication: 1.8.1 Borana proverbs 1.8.2 Familiar tales 1.8.3 Familiar fables 1.8.4 Borana cultural songs 1.8.5 Borana cultural dances 1.8.6 Borana cultural drama		
1.9	Explain the use ofthe below cultural institutions/associations in HIV/AIDS campaigns: 1.9.1 "*Gadaa*" 1.9.2 "*Qaalluu*" 1.9.3 "*GumiiGaayyoo*" 1.9.4 "*Daboo*"		

	1.9.5 "*Afoosha*"		
1.10	How do the cultural leaders, religious people, and health professionals in this district cooperate in the HIV/AIDS campaigns?		
1.11	Explain the cultural resources assisting HIV/AIDS campaigns in this community.		
1.12	Explain the cultural practices that contribute to the spread of HIV/AIDS.		
1.13	How do you view the unique cultural opportunities that support the campaigns against HIV/AIDS in this pastoralist community?		
1.14	Explain the traditional medicine culturally used to tackle the HIV/AIDS epidemic, if any.		
1.15	How do you suggest they integrate HIV/AIDS communication into the Borana culture?		

2. Religious/spiritual orientation in HIV/AIDS communication

S/N	Questioning route	Summary/ Key points	Notable quotes
2.1	Explain the coordination between your office and religious institutions to address HIV/AIDS issues in this community.		
2.2	Explain the religious/spiritual constructs that support HIV/AIDS communication in this community, such as: 9.4.1 Beliefs 9.4.2 Norms 9.4.3 Values 9.4.4 Traditions 9.4.5 Attitude 9.4.6 Practices		
2.3	Explain the religious/spiritual factors that hinder HIV/AIDS messaging in this community.		
2.4	What is your view about HIV/AIDS communication from a religious/spiritual perspective?		

3. Gender orientation in HIV/AIDS communication

S/N	Questioning route	Summary/ Key points	Notable quotes
3.1	What is your view on HIV/AIDS communication from a gender perspective?		
3.2	How do you view the different gender's participation in tackling the HIV/AIDS epidemic in this community?		
3.3	Do you think men and women in this community have equal opportunities to access HIV/AIDS information?		
3.4	Explain the gaps in HIV/AIDS communication because of gender factors.		
3.5	Explain the role of gender-oriented HIV/AIDS communication in this community.		
3.6	Explain the negative gender roles that affect HIV/AIDS communication in this community.		
3.7	Explain the HIV/AIDS communication strategies that consider gender differences.		
3.8	Which HIV/AIDS communication strategies do you suggest from a gender perspective?		

4. Behavioural change in relation to HIV/AIDS communication

S/N	Questioning route	Summary/ Key points	Notable quotes
4.1	Do you think HIV/AIDS communication in this community is bringing the intended behavioural change?		
4.2	Do you think HIV/AIDS communication in your community focuses on individual or social behavioural change?		
4.3	Explain the communication examples/models typically used to communicate HIV/AIDS messages.		

4.4	What is your view on the effectiveness of the HIV/AIDS communication models used in your community?		
4.5	Explain the cultural practices contributing to positive behavioural change in terms of HIV/AIDS.		
4.6	Explain the spiritual/religious practices contributing to behavioural change in terms of HIV/AIDS.		
4.7	Explain the unique cultural opportunities in this community that contribute to HIV/AIDS communication.		
4.8	Explain the cultural practices that impede behavioural change when it comes to HIV/AIDS.		
4.9	What do you suggest for this community to bring about behavioural change regarding HIV/AIDS?		

5. HIV/AIDS communication approach

S/N	Questioning route	Summary/ Key points	Notable quotes
5.1	Explain the communication approaches you use to address HIV/AIDS issues in this community.		
5.2	Explain the communication channels you use to address HIV/AIDS issues.		
5.3	What is your view on the appropriateness of HIV/AIDS communication approaches to the contexts of this community?		
5.4	What is your view on the role of this community in designing HIV/AIDS communication approaches?		
5.5	What is your view on the familiarity of the HIV/AIDS communication approaches to the contexts of this community?		
5.6	What is your opinion on the participatory nature of the HIV/AIDS communication approaches in this community?		
5.7	What HIV/AIDS communication approaches do you suggest for this community?		

APPENDIX F: FGI QUESTIONING ROUTE: FEMALE HOUSEHOLDS

PART ONE: FGI INTERVIEW REGISTRATION FORM

Pseudonym			
In-depth interview number			
Date of in-depth interview			
Time of in-depth interview		to	
Tape number			
Location of in-depth interview			
Moderator's name			
Moderator's phone number			
Assistant moderator's name			
Assistant moderator's phone number			

BIOGRAPHICAL INFORMATION

S/N	
Pseudonym	
Sex	
Marital status	
Age	
Religion	
Education	
Administrative district	
Administrative *kebele*	
Responsibility	
Phone number	

PART TWO: FGIs QUESTIONING ROUTE

1. Cultural embedment in HIV/AIDS communication

S/N	Questioning route	Summary/ Key points	Notable quotes
1.1	What is your view on the health behaviour of this community?		
1.2	What is your view on HIV/AIDS problems in this community?		
1.3	Tell me about the organisations working on HIV/AIDS in this district.		
1.4	Tell me about the role of communication in HIV/AIDS.		
1.5	What is your view on the integration of HIV/AIDS communication into the cultural contexts of this community?		
1.6	What is your view on language clarity to address HIV/AIDS issues?		
1.7	What is your role in designing HIV/AIDS messages for this community?		
1.8	What is your view on the use of Borana cultural resources with reference to HIV/AIDS communication such as: 1.8.1 Borana proverbs 1.8.2 Familiar tables 1.8.3 Familiar fables 1.8.4 Borana cultural songs 1.8.5 Boran cultural dance 1.8.6 Borana cultural drama		
1.9	Explain the use the cultural institutions/associations in HIV/AIDS campaigns, such as 1.9.1 "*Gadaa*" 1.9.2 "*Qaalluu*" 1.9.3 "*Gumii Gaayyoo*"		

	1.9.4 "*Daboo*" 1.9.5 "*Afoosha*"		
1.10	How do the cultural leaders, religious people, and health professionals in this district cooperate in the HIV/AIDS campaigns?		
1.11	Explain the cultural resources assisting HIV/AIDS campaigns in this community.		
1.12	Explain the cultural practices that contribute to the spread of HIV/AIDS.		
1.13	How do you view the unique cultural opportunities that support the campaigns against HIV/AIDS in this pastoralist community?		
1.14	Explain the traditional medicine culturally used to tackle the HIV/AIDS epidemic, if any.		
1.15	How do you suggest integrating HIV/AIDS communication into the Borana culture?		

2. Religious/spiritual orientation in HIV/AIDS communication

S/N	Questioning route	Summary/ Key points	Notable quotes
2.1	Explain the coordination between your office and religious institutions to address HIV/AIDS issues in this community.		
2.2	Explain the religious/spiritual issues that support HIV/AIDS communication in the community such as: 2.2.1 Beliefs 2.2.2 Norms 2.2.3 Values 2.2.4 Traditions 2.2.5 Attitude 2.2.6 Practices		
2.3	Explain the religious/spiritual factors that hinder HIV/AIDS messages in this community.		
2.4	What is your view on HIV/AIDS communication		

	from a religious/spiritual perspective?		

3. Gender orientation in HIV/AIDS communication

S/N	Questioning route	Summary/ Key points	Notable quotes
3.1	What is your view on HIV/AIDS communication from a gender perspective?		
3.2	How do you view the gender participation to tackle the HIV/AIDS epidemic in this community?		
3.3	Do you think men and women in this community have equal opportunity to access HIV/AIDS information?		
3.4	Explain the gaps in HIV/AIDS communication due to gender factors.		
3.5	Explain the role of gender-oriented HIV/AIDS communication in this community.		
3.6	Explain the negative gender roles that affect HIV/AIDS communication in this community.		
3.7	Explain the HIV/AIDS communication strategies in your community that consider gender differences.		
3.8	Which HIV/AIDS communication strategies do you suggest from a gender perspective?		

4. Behavioural change in relation to HIV/AIDS communication

S/N	Questioning route	Summary/ Key points	Notable quotes
4.1	What is your view on HIV/AIDS communication in this community in bringing the intended behavioural change?		
4.2	Do you think HIV/AIDS communication in your community focuses on individual or social behavioural change?		
4.3	Explain the communication examples/models typically used to communicate HIV/AIDS messages.		

4.4	What is your view on the effectiveness of the HIV/AIDS communication models used in your community?		
4.5	Explain the cultural practices contributing to positive behavioural change about HIV/AIDS.		
4.6	Explain the spiritual/religious practices contributing to behavioural change in terms of HIV/AIDS.		
4.7	Explain the unique cultural opportunities in this community that contribute to HIV/AIDS communication.		
4.8	Explain the cultural practices that impede behavioural change in terms of HIV/AIDS.		
4.9	What do you suggest for this community to bring about behavioural change in terms of HIV/AIDS?		

5. HIV/AIDS communication approach

S/N	Questioning route	Summary/ Key points	Notable quotes
5.1	Explain the HIV/AIDS communication approaches you use to address HIV/AIDS issues in this community.		
5.2	Explain the communication channels you use to address HIV/AIDS issues.		
5.3	What is your view on the appropriateness of HIV/AIDS communication approaches in the contexts of this community?		
5.4	What is your view on the role of this community in designing HIV/AIDS communication approaches?		
5.5	What is your view on the familiarity of the HIV/AIDS communication approaches to the contexts of this community?		
5.6	What is your opinion on the participatory nature of the HIV/AIDS communication approaches in		

	this community?		
5.7	What HIV/AIDS communication approaches do you suggest for this community?		

APPENDIX G: FGI QUESTIONGING ROUTE: MALE HOUSEHOLDS

PART ONE: FGI INTERVIEW REGISTRATION FORM

Pseudonym			
In-depth interview number			
Date of in-depth interview			
Time of in-depth interview		to	
Tape number			
Location of in-depth interview			
Moderator's name			
Moderator's phone number			
Assistant moderator's name			
Assistant moderator's phone number			

BIOGRAPHICAL INFORMATION

S/N	Pseudonym	Sex	Marital Status	Age	Religion	Education	District	*Kebele*	Phone number
1									
2									
3									
4									
5									
6									

PART TWO: FGI QUESTIONING ROUTE

1. Cultural embedment in HIV/AIDS communication

S/N	Questioning route	Summary/ Key points	Notable quotes
1.1	What do you know about HIV/AIDS as an illness?		
1.2	How do you see the role of communication to prevent HIV/AIDS?		
1.3	What is your opinion about the role of Borana culture to prevent HIV/AIDS from spreading?		
1.4	How do you see the appropriateness of HIV/AIDS communication regarding the Borana contexts such as? 1.4.1 Language 1.4.2 Norms 1.4.3 Values 1.4.4 Belief system 1.4.5 Religion 1.4.6 Gender 1.4.7 Environment		
1.5	How do you view the integration of HIV/AIDS communication messages into the Borana cultural resources?		
1.6	Explain your role in the HIV/AIDS communication in this community.		
1.7	How do you see the use of cultural resources such as the below to communicate HIV/AIDS? 1.7.1 Borana proverbs 1.7.2 Familiar tales 1.7.3 Familiar fables 1.7.4 Borana cultural songs 1.7.5 Borana cultural dances 1.7.6 Borana cultural drama		
1.8	Explain the role of cultural institutions/associations in the prevention of the		

	spread of HIV/AIDS such as: 1.8.1 "*Gadaa*" 1.8.2 "*Qaalluu*" 1.8.3 "*Gumii Gaayyoo*" 1.8.4 "*Daboo*" 1.8.5 "*Afoosha*"		
1.9	Explain the cultural practices that contribute to HIV/AIDS spread in this community.		
1.10	What is your view on open discussions about sexual matters in this community?		
1.11	Explain your opinion on Borana cultural marriage from the perspective of HIV/AIDS.		
1.12	Explain the unique cultural resources in this community that help to prevent HIV/AIDS infection.		
1.13	What are cultural remedies to cure HIV/AIDS?		
1.14	What do you recommend to integrate HIV/AIDS communication with the socio-cultural contexts of this community?		

2. Religious/spiritual orientation of HIV/AIDS communication

S/N	**Questioning route**	**Summary/ Key points**	**Notable quotes**
2.1	Tell me about the role of religious/spiritual institutions to prevent HIV/AIDS in this community.		
2.2	How do you view the integration of religious teachings with HIV/AIDS message?		
2.3	What is your view on HIV/AIDS communication regarding religious differences?		
2.4	What is your view on the cure for HIV/AIDS from a religious/spiritual perspective?		
2.5	In your opinion, what are the religious/spiritual beliefs that assist the campaigns against		

	HIV/AIDS in this community?		
2.6	Tell me about the religious beliefs that accelerate the spread of HIV/AIDS.		
2.7	What do you recommend when it comes to HIV/AIDS communication from a religious/spiritual perspective?		

3. Gender orientation of HIV/AIDS communication

S/N	Questioning route	Summary/ Key points	Notable quotes
3.1	How do you see gender participation in the HIV/AIDS campaigns in your community?		
3.2	What is your view of men and women in this community; are they equally responsible to prevent HIV/AIDS?		
3.3	What is your view on HIV/AIDS communication considering gender issues?		
3.4	What is your view on gender discrimination in HIV/AIDS message communication?		
3.5	Tell me about the gender perception on HIV/AIDS campaigns in your community.		
3.6	Are there gender-related factors that contribute to HIV/AIDS in your community?		
3.7	What are your suggestions for HIV/AIDS communication in terms of gender?		

4. Behavioural change in reaction to HIV/AIDS communication

S/N	Questioning route	Summary/ Key points	Notable quotes
4.1	What is your view on the behavioural changes in your community because of HIV/AIDS communication so far?		
4.2	What are you doing at family level to prevent HIV/AIDS?		

4.3	What are you doing at community level to prevent HIV/AIDS?		
4.4	Do you think HIV/AIDS communication in your community focuses on individual or social behavioural change?		
4.5	What is your view on HIV/AIDS communication strategies in this community in terms of behavioural change?		
4.6	Tell me about the cultural practices that hinder behavioural change about HIV/AIDS.		
4.7	Tell me about the external factors in your community that affect behavioural change towards HIV/AIDS.		
4.8	What do you recommend to bring about the intended behavioural change regarding HIV/AIDS?		

5. HIV/AIDS communication approach

S/N	Questioning route	Summary/ Key points	Notable quote
5.1	Tell me more about the approaches of HIV/AIDS communication in your community.		
5.2	What is your view on the HIV/AIDS communication approaches and the socio-cultural contexts of this community?		
5.3	What are the channels used to communicate HIV/AIDS messages in this community?		
5.4	How do you see the participatory nature of HIV/AIDS communication approaches in this community?		
5.5	Tell me about the gaps in the HIV/AIDS communication approaches in this community.		
5.6	What is your view on the environmental relevance of HIV/AIDS communication approaches in your community?		
5.7	What is your view on HIV/AIDS communication		

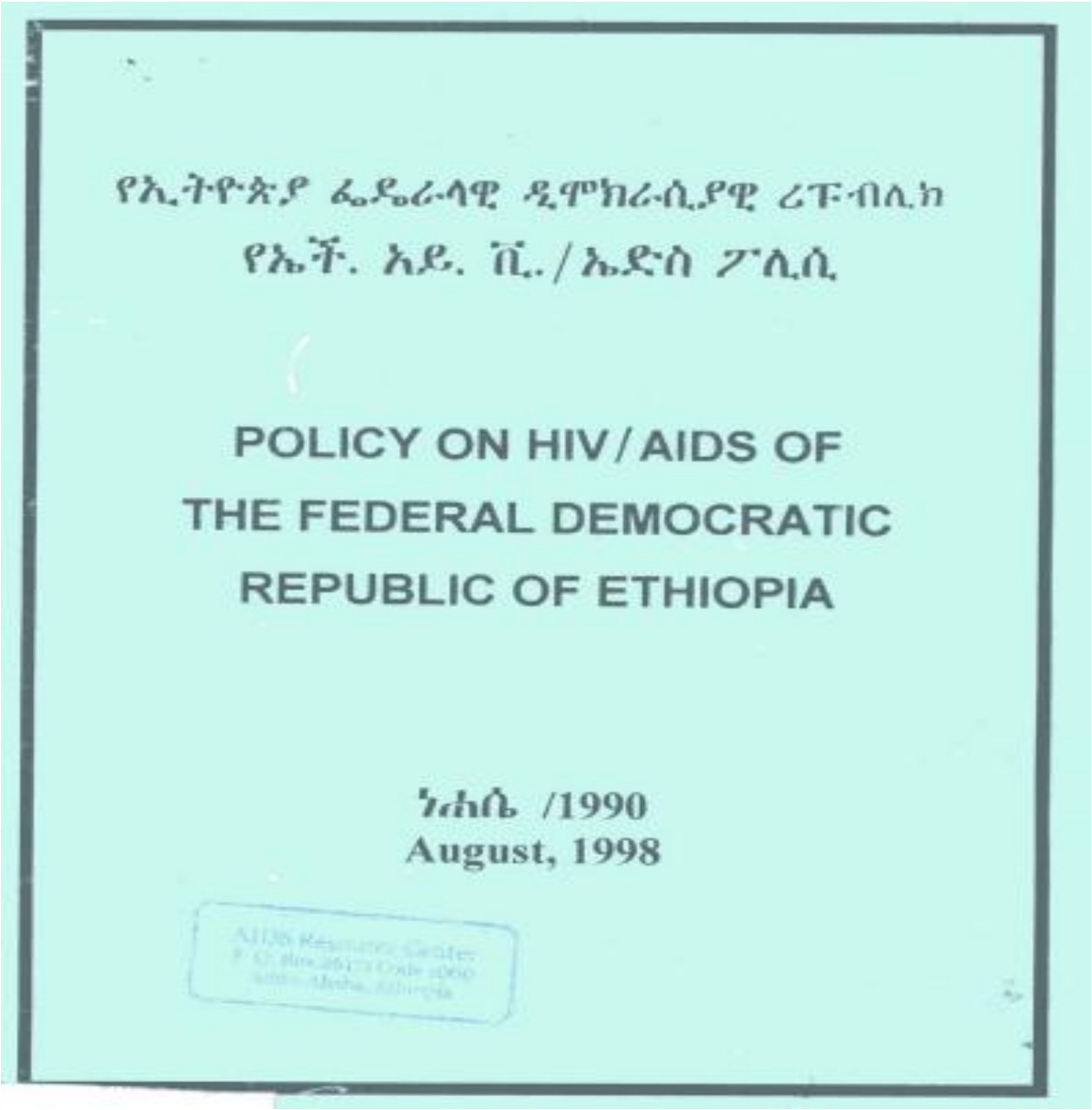
	approaches and gender?		
5.8	Do you think the HIV/AIDS communication approaches have religious/spiritual relevance?		
5.9	What kind of HIV/AIDS communication approaches do you recommend for this community?		

APPENDIX H: DOCUMENT ANALYSIS CHECKLIST

CHECKLIST FOR DOCUMENT ANALYSIS

Type of the document	
The physical characteristics of the document	
Date/year	
Author/responsible body for the content	
Target audiences of the document	
The main topics of the document	
Socio-cultural contents to address HIV/AIDS messages	
Gender contents to address HIV/AIDS messages	
Religious/spiritual contents to address HIV/AIDS messages	
Communication strategies to address HIV/AIDS messages	
Socio-cultural appropriateness of the communication strategies regarding the pastoralist community	
Appropriateness of the behavioural change model/theory to the pastoralist community	
Focus given to the Indigenous contexts of the pastoral community (language, belief systems, values, norms, rural contexts, ecology, traditional communication channels, traditional institutions)	
Culturally specific communication strategies to tackle harmful traditional practices that spread HIV/AIDS	
Special focus given to the underprivileged population group (pastoralist community, rural people, women)	
Gaps in the communication approaches regarding HIV/AIDS communication	
Special focus given to the underprivileged population group (pastoralist community, rural people, women)	
Future direction for contextualised HIV/AIDS communication	
Further remarks	

APPENDIX I: HIV/AIDS POLICY OF ETHIOPIA USED FOR DOCUMENT ANALYSIS



የኢትዮጵያ ፌዴራላዊ ዲሞክራሲያዊ ሪፑብሊክ

የኤች. አይ. ቪ./ኤድስ ፖሊሲ

POLICY ON HIV/AIDS OF

THE FEDERAL DEMOCRATIC

REPUBLIC OF ETHIOPIA

ነሐሴ /1990

August, 1998

Source: MoH 1999