UNIVERSITY OF MEDIA, ARTS AND COMMUNICATION (UniMAC)

COMMUNICATION STRATEGIES IN CURBING SEXUALLY TRANSMITTED DISEASES (STDs) IN THE CHORKOR COMMUNITY

BY

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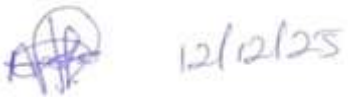
DECLARATION

DECLARATION BY STUDENT– DISSERTATION

I hereby declare that this research is a result of my own original research and that, no part of it has been presented for another degree in this university or any other higher education institute. I further declare that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

WINNIFRED ARABA WILSON	MADC24060		12/12/25
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SUPERVISOR'S CERTIFICATION

I hereby certify that the preparation of this dissertation was supervised by me in accordance with the guidelines of supervision of dissertation laid down by the University of Media, Arts and Communication UniMAC-IJ.

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ABSTRACT

Despite ongoing efforts to raise awareness about curbing Sexually Transmitted Diseases (STDs), it remains a significant public health concern in Ghana, affecting young people and marginalised groups. The prevalence of STIs varies across different countries worldwide, depending on a complex interplay of socioeconomic, demographic, and behavioral factors (WHO, 2020). According to UNAIDS 2009 estimates, sub-Saharan Africa accounted for 68% of global HIV infections, 68% of new adult HIV infections, 92% of new infections in children, and 72% of all AIDS-related deaths. Reports of national STD rates in Ghana indicate that 3.4% of the Ghanaian population is estimated to have STDs, with a prevalence as high as 28% showing symptoms (GAC 2020). The continuous spread of misinformation, cultural taboos, stigma, and limited access to accurate sexual health information hinder the effectiveness of prevention and control efforts. Development communication has become one of the various methods for engaging the public in a more friendly and social manner. Various studies conducted by scholars on the transmission of STDS/STIs, pay more attention to sexual activities that lead to the spread of the diseases, but give less attention to non-sexual means of transmission. This study investigates how interpersonal and community-based communication strategies can be used to address non-sexual means of STDs/STIs transmission, such as blood transfusion and mother-to-child. Using the Health Belief Model and the Diffusion of Innovation theory, the research adopts a mixed-method approach for data collection; interviews with key informants, and a community-based survey (the use of questionnaires). The findings of this study is expected to demonstrate the important role that development communication plays in improving STD-related knowledge.

Keywords

diffusion of innovation; health belief model; National AIDS Commission; National AIDS Control Programme; Non-Governmental Organisation.

DEDICATION

I dedicate this project to Mrs Yvonne Adjetey-Sorsey for her massive support and sacrifice throughout my study period and to every other individual whose support has made this successful.

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CHAPTER ONE

INTRODUCTION

1.1 Background

Sexually Transmitted Diseases (STDs), also known as Sexually Transmitted Infections (STIs), are infections that are spread through sexual relations or contact. Although both mean the same thing, that is, diseases caused by some bacterial and viral infections, an infection (STI) cannot be called a disease (STD) unless the patient shows symptoms (LLC, 2025). The World Health Organisation (WHO) (2022) refers to STDs as a group of more than thirty different bacteria, viruses, and parasites that are spread predominantly through sexual contact. In 2020, the WHO estimated a global incidence of 374 million new cases of four curable STIs, including 128 million chlamydia cases, 82 million gonorrhoea cases, 156 million trichomoniasis and 7 million syphilis cases. The prevalence of STIs varies across different countries worldwide, depending on a complex interplay of socioeconomic, demographic, and behavioral factors (WHO, 2020). According to UNAIDS 2009 estimates, sub-Saharan Africa accounted for 68% of global HIV infections, 68% of new adult HIV infections, 92% of new infections in children, and 72% of all AIDS-related deaths. In the same year, regional estimates suggest that more than 14.1 million children have lost one or both parents to AIDS. The HIV/AIDS epidemic continues to have a disproportionate impact on women and girls in sub-Saharan Africa, with women aged 15–24 years being eight times more likely to be infected with HIV than their male counterparts.

STDS in Ghana

Despite efforts by the government and some non-governmental organisations within the country to limit the rate of sexually transmitted diseases (STDs), it remains a significant concern in our health sector as cases in the country continue to rise (Panford et al, 2001). Sexually Transmitted

Diseases such as HIV/AIDS, gonorrhoea, syphilis, chlamydia, and others continue to rise in some parts of the country, and though these infections and diseases are transmitted through sexually related activities, other means of transmission, such as from mother-to-child during childbirth and blood transfusion, are other factors of transmission. Reports of national STD rates in Ghana indicate that 3.4% of the Ghanaian population is estimated to have STDs, with a prevalence as high as 28% showing symptoms (GAC 2020). Gonorrhoea and other infectious diseases were introduced to Ghana before the colonial period by European settlers. By the 1920s, both gonorrhoea and syphilis were widespread in southern Ghana (3760 and 1503 cases, respectively, in 1925-26) and soon disseminated throughout the country (Pellow, 1994). By 1946, there were 82,430 cases of gonorrhoea and 9340 cases of syphilis--an increase exacerbated by the influx of laborers and troops during World War II. Although there was no government department responsible for the control of sexually transmitted diseases (STDs), sulpha drugs were widely utilized and distributed through the black market. It was not until 1986, when the first case of acquired immunodeficiency syndrome (AIDS) was diagnosed in Ghana, that government health officials gave serious attention to STDs. At that time, the most prevalent STDs were gonorrhoea, chlamydia, and trichomonas.

By 1992, 10,285 AIDS cases had been reported to the National AIDS Control Program, and high rates of human immunodeficiency virus (HIV) infection existed in prostitutes and blood donors (Pellow, 1994). Awareness of the role that STDs play as co-factors in HIV acquisition prompted, in 1993, the decision to integrate AIDS and STD control programs. Campaigns to train health workers in AIDS/STD detection, treatment, and prevention were initiated. Women's subordinate socioeconomic status, which renders them unable to insist on condom use and denies them access to STD treatment, remains a major obstacle. Despite the historical background of STDs/STIs in the country, deep-rooted cultural beliefs and stigmatization often discourage individuals from seeking treatment in our society. Amoah and Anane (2021) argue

that the fear of social judgment frequently prevents individuals from disclosing their STDs status or visiting any health facilities for treatment, hence serving as an added factor to its escalation in the country.

Development communication is one of the main strategies used to reduce STDs/STIs in some communities in the country, serving as way to increase awareness, advocate for policies, and promote behavioural change. Organizations such as the Ghana AIDS Commission (GAC), USAID Ghana, and the Ghana Football Association, among others, have campaigned against sexual practices that cause STDs through public campaigns involving sports personalities and visual messaging, condom distribution initiatives targeting youth, community engagements, and other outreach strategies (USAID, 2017). Review of extant literature and research studies reveals that STDs are not solely spread through sexual activity but also through non-sexual means of transmission, such as from mother to child during childbirth, blood transfusions, and sharing needles with infected individuals.

This research, therefore, explores the effective use of interpersonal and community-based communication strategies as tools of development communication strategies through interpersonal interaction and mass media. These strategies will aid in addressing the spread of STDs, not only through sexually related activities but also through non-sexual means of transmission within our society by engaging participants and key informants to address the issue and promote development collaboratively. The accurate identification of STDs and their effective management represent essential strategies, necessary to improve reproductive health and prevent these diseases (GAC, 2020). The study employs a convergent parallel mixed methods design, in which quantitative and qualitative data are collected simultaneously, analysed independently, and subsequently integrated during the interpretation stage (Almutairi et al., 2025). This design is widely recognized as one of the most effective strategies for addressing complex social and health-related research questions, as it enables researchers to capitalize on

the strengths of both approaches while minimizing their respective limitations (Creswell & Plano Clark, 2018; Fetters, Curry, & Creswell, 2013). In this framework, surveys will generate statistical evidence on levels of awareness, knowledge, and preventive behaviors related to sexually transmitted diseases (STDs). At the same time, interviews and focus groups will provide deeper insights into participants' lived experiences, cultural interpretations, and community responses. The simultaneous collection of data strands reduces the influence of time-related changes, ensuring that findings from both perspectives are drawn from the same contextual realities (Bryman, 2016; Creswell & Creswell, 2018).

1.3 Problem Statement

Initiatives by organizations such as the Ghana AIDS Commission and the Planned Parenthood Association of Ghana (PPAG) have utilized peer education, mass media campaigns, community theatre, and digital platforms to disseminate STD prevention messages and encourage safer sexual practices (UNFPA Ghana, 2023; PPAG, 2021). Various studies conducted by scholars on the transmission of STDS/STIs, pays less attention to other factors that lead to the transmission of these diseases and infection. For instance, Dery et. al (2021) in their study conducted on female sex workers proved that the knowledge of STDs transmission through sexual activities was high, but the study did not cover non-sexual means of contracting these diseases among the sex-workers. . Also, Dery et. al (2021) in their study conducted on female sex workers proved that the knowledge of STDs transmission through sexual activities was high, but the study did not cover non-sexual means of contracting these diseases among the sex-workers. In another study by Thompson and Jones (2019) on Media Representation of Non-Sexual STD Transmission, it was noted that media articles and television programs campaigned on sexual activities that lead to STDs but less frequently mentioned other means of transmission.

These studies and other reviewed articles, which will be analysed in the context of this study, addressed the sexual means of contracting STDs through sexual activities. The question remains:

how often are other means of contracting STDs and STIs communicated to people within our communities? This study aims to assess how interpersonal communication and community-based communication strategies can help curb STDs/ STIs by paying attention to the sexual and non-sexual means of transmission.

1.4 Research Objectives

1.4.1 General Objectives

In the quest to identify the most effective development communication strategies for this study, this research will investigate how interpersonal and community-based communication strategies aid in addressing STDs and STIs, while also considering other factors of transmission that are often overlooked.

1.4.2 Specific Objectives

1. To explore the cultural and contextual factors shaping how community members interpret and respond to STDs/STIs-related messages.
2. To evaluate the role of interpersonal and community-based communication strategies in influencing preventive behaviours.
3. To integrate findings to provide recommendations for improving communication strategies.

1.5 Research Questions

1. What are the cultural and contextual factors that affect how individuals perceive and act on STD-related messages?
2. How do interpersonal and community-based communication strategies influence preventive behaviours against STDs?
3. How do quantitative and qualitative findings converge to explain the effectiveness of development communication strategies in curbing STDs?

1.6 Significance Of Study

The import of this study lies in the involvement of both academic and practical development practices, particularly within the domains of Development Communication and Health Communication. Although extensive information on STDs and STIs prevails, their high frequency among young people and other vulnerable populations especially emphasizes on the sexual means of transmission and ongoing challenges, which include misinformation, stigma, and limited awareness. This research, therefore, provides valuable insight into how communication processes, strategies, and interventions can be designed and implemented effectively to respond to these challenges.

Academically, the study provides empirical evidence on the role of communication and how it shapes individuals' knowledge, attitudes, and behaviors in relation to these infections and diseases, drawing on existing literature on Development and Health communication. Research advancement addresses the gaps in the literature related to the experience of the vulnerable population by highlighting socio-cultural and structural barriers that hinder effective communication and behaviour of non-sexual means of STDs/STIs transmission. From a practical development perspective, however, the study generates actionable insights for policymakers, public health practitioners, NGOs, and other organisations involved in STD/STI prevention and treatment. It emphasizes the need to channel communication strategies to enhance awareness of non-sexual means of transmitting STDs/STIs. This is in relation to the knowledge of STDs, where understanding will be deepened on social, cultural, and behavioural factors that interact with health communication efforts.

1.7 Scope Of The Study

The study will focus on an urban community in the Greater Accra region, specifically, the Chorkor community within the Accra Metropolis in Ghana. With a population of about 3,000

indigenes, the community is known as a densely populated fishing community (Mensah, 2018). The study will, however, not focus on all types of STDs, but will specifically be centred on HIV/AIDS, gonorrhoea, syphilis, and chlamydia, with its targeted population being young people and the youth, from 10-30 years.

The study will engage participants using purposive sampling with a frame of key stakeholders (health workers, peer educators, community centers, etc) to engage key informants and the convenience sampling approach to select other participants to complete the study. This sampling approach will help prevent biases or under-represent any of the groups involved in the study.

This research will also offer a broader understanding of the practical role development communications plays in our public health education concerning STDs in Ghana. Using the Health Belief Model (HBM) and the Diffusion of Innovations Theory (DOI), it will generate more participatory communication strategies with effectiveness and inclusivity, to assist health communicators, policy makers, media practitioners, NGOs, and other related bodies to improve their communication strategies to help curb STDs, both through sexual activities and non-sexually transmitted diseases. The HBM will explain how individuals are aware of the risks for severe diseases and that, a change in their behaviour can prevent such risk, and the DOI will explain how new ideas and practices spread within a community. The study will explore how messages in line with our culture, strategic use of the media, and community outreaches can increase awareness, correct misinformation and promote a change in behaviour of people in our communities.

1.8 Research Design

This study will adopt the mixed-method approach, which is suitable for engaging both key informants and selected participants in the study. That is, the use of qualitative and quantitative research methods. Specifically, the qualitative approach will be done through in-depth interviews with key informants, and the quantitative approach will be done through surveys, by

administering questionnaires. A total of 110 respondents will be taken; 10 key informants (health officers, policy makers, peer educators, etc) and 100 of the youthful population. This will help get specific information and feedback from the key informants' perspective in curbing STDs in the country, as well as gather the necessary data from participants for the study. Participants of the National AIDS/STI Control Programme under the Disease Control and Prevention Department of the Ghana Health Service, by the National AIDS Commission (NAC), will be sampled. The study will also adopt the purposive sampling technique to engage key informants and the convenience sampling technique to engage other participants. Additionally, the Statistical Product and Solution Service (SPSS) analytical tool would be used for collecting data analysis. However, the theoretical framework and data analytical frameworks will be employed in the study, and findings will be presented in light of the chosen theories.

According to the Population and Housing Census (2021), the Korle-Klottey Municipal Assembly, which contains the Chorkor area, holds a population of 68,633. Being a fishing community, the mobility of men and women creates an environment where transactional sex is common and this increases the vulnerability of STDs/STIs. Young people in the community stand at a higher risk despite public health campaigns; misconceptions about non-sexual transmission routes remain widespread.

1.9 Organization Of The Study

This study will be divided into five (5) chapters.

Chapter 1 will consist of the introduction, background of the study, objectives of the study, problem statements, research questions, scope of the study, justification of the study, and organization of the study.

Chapter 2 will explore theories related to the study by reviewing previous articles, conceptual frameworks, and identify the research gaps in previous studies and why this current study is necessary.

Chapter 3 will provide the research design, population and sampling size as well as the sampling techniques. It will also look at the tools for data collection and data analysis.

Chapter 4 will primarily discuss all data gathering from participants during in the study.

Chapter 5, being the final chapter, will include the summary, study findings, conclusions and recommendations for future study.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents the conceptual and theoretical foundations underpinning the study. It begins with the conceptual framework, which outlines five interconnected concepts relevant to STDs/STIs and communication strategies. The chapter then proceeds to the theoretical framework, drawing on two theories that guide the study's analysis. The relevance of these theories to the research is then elaborated and supported with a diagram. Finally, the chapter reviews relevant empirical literature, highlighting studies that inform the current research while identifying gaps that justify this investigation.

2.1 Background

Sexually transmitted infections (STIs) remain one of the most pressing health concerns in Ghana, with significant social, economic, and developmental implications. Although global progress has been made in reducing the prevalence of major infections such as HIV, syphilis, gonorrhoea and chlamydia, Ghana continues to experience stead rates of both symptomatic and asymptomatic infections across diverse population groups (World Health Organisation (WHO), 20220. According to the Ghana Demographic and Health Survey (GDHS, 2022), the prevalence of self-reported STIs among sexually active women and men aged 15-49 remains high, with youth and young adults representing the majority of those affected. Among adolescent girls aged 15 to 19, STI prevalence increased from approximately 2.2% in 2003 to 7.1% in 2022, while among their male counterparts, the increase was from 2.2% in 2003 and 12.5% in 2022. This upward trend underscores an alarming pattern of early sexual initiation and inconsistent condom use among Ghanaian adolescents (Ghana Statistical Service, 2023).

Research conducted by Seidu et al. (2021), which analyzed data from the 2014 GDHS on 3,051 sexually active men aged 15 to 59, revealed a 6% prevalence rate of self-reported STIs within the 12 months preceding the survey. The study found that younger men, particularly those aged 25 to 34, were nearly three times more likely to report an infection compared with older respondents. Men who engaged in multiple sexual partnerships were also significantly more vulnerable than those who practised monogamy. These findings confirm that sexual risk behaviours, coupled with limited access to accurate health information, contribute to persistent STI transmission within this demographic (Seidu et al., 2021).

Facility-based studies provide complementary insights into Ghana's STI burden, revealing notable gender disparities. Adanu et al. (2019) observed that women accounted for approximately 72 % of patients attending STI clinics in the Ho Municipality. A significant number of these women were unmarried, reflecting the vulnerability of single, sexually active females in urban and peri-urban areas. The study also highlighted the predominance of syndromic treatment approaches, which rely on visible symptoms rather than laboratory diagnoses, potentially leading to under- or over-treatment (Adanu et al., 2019). Moreover, the Ghana Health Service (2023) reported that many women experience repeated or chronic infections because of limited access to quality diagnostic and treatment services.

2.1.1 Demographics of Affected Persons.

The prevalence of STIs in Ghana shows distinct demographic and geographic patterns. Adolescents and young adults remain the most affected, as several national surveys have confirmed that individuals aged 15 to 34 account for the majority of new infections (GSS, 2023). Studies indicate that early sexual initiation, transactional sex, and multiple partnerships are among the key behavioral drivers within this age cohort (Owusu-Ansah et al., 2021). Gender differentials also persist, with females—especially adolescent girls—facing heightened vulnerability

because of biological susceptibility, socioeconomic disadvantage, and unequal power relations in sexual decision-making (Ameyaw et al., 2022).

Regional analysis shows marked variations across Ghana. The Ashanti Region records some of the highest rates of underage sexual activity, especially in districts such as Akrofuom, Amansie South, and Obuasi East. The Eastern Region follows closely, with a high proportion of adolescent males reporting multiple sexual partners (GSS, 2023). The Bono and Western North Regions also exhibit elevated rates of risky sexual behaviors among adolescent girls, particularly those not enrolled in school (Ghana Health Service, 2023). These patterns reflect broader socioeconomic conditions, as regions with limited access to comprehensive sexual health education and services tend to experience higher infection rates (Mensah & Boadu, 2022).

Tabular form of the risky rates of STDs/STIs among the youth.

Characteristic	Details / Data
Age groups	Adolescents (15-19), young adults (20-29, 25-34) show higher STI/HIV incidence. E.g., Seidu et al.: men 25-34 highest risk; adolescents for rising STIs among girls and boys.
Gender	Females, especially adolescent girls, have a significant STI burden; increased sexual activity before age 15, and multiple sexual partners are more common among adolescent girls in certain regions.
Region / District	Ashanti Region shows many districts with high rates of underage sexual activity among females (e.g. Akrofuom, Amansie South etc.). The Eastern Region has high rates among males. Multiple sexual partners among adolescent girls are high in Bono, Western North, etc.

Nature/types of infections	In addition to HIV, curable bacterial STIs are common (gonorrhea, chlamydia). Also, symptoms (discharge, sores) are often reported. Many cases are asymptomatic, especially in women.

Source: Researcher's Field Data (2025)

2.1.2 Nature and Scope of Infections

The spectrum of sexually transmitted infections in Ghana includes both viral and bacterial diseases, with HIV, syphilis, gonorrhea, chlamydia, and trichomoniasis being the most prevalent (Amoako et al., 2020). Many cases, however, remain undiagnosed because of stigma, inadequate laboratory facilities, and the preference for self-medication through pharmacies and herbal treatments (Nyameaye et al., 2023). A study by Hutton-Nyameaye et al. (2023) in the Ho Municipality revealed that many community pharmacists treat STIs using syndromic management rather than laboratory confirmation, often leading to treatment failure or reinfection. Similarly, data from the National AIDS Control Programme (NACP, 2023) show that adult HIV prevalence remains highest in the Bono Region (2.12%), Greater Accra (1.98%), and Eastern Region (1.95%), with Western North and Ashanti following closely.

Beyond HIV, bacterial infections such as gonorrhoea and chlamydia are increasingly detected in health facilities, particularly among sexually active youth and women of reproductive age (Agyemang et al., 2022). However, many cases go untreated because of mild or absent symptoms. Ampofo et al. (2021) reported that approximately 19% of women in urban Accra reported STI-related symptoms, yet only 35% of those sought medical care. This underscores the persistent gaps in awareness, healthcare access, and health-seeking behaviour.

2.1.3 Risk Factors and Emerging Trends

Several structural and behavioral factors contribute to Ghana's continuing STI burden. These include low levels of condom use, inadequate sexual health education, cultural taboos surrounding sexual discussions, and limited integration of STI services within primary healthcare systems (Appiah et al., 2023). Misinformation—often spread through peer networks and social media—also exacerbates risky behaviors among young people (Doku & Addo, 2020). Furthermore, emerging antimicrobial resistance, particularly to gonorrhea treatments, poses an additional challenge to effective disease control (World Health Organization, 2022).

At the same time, there has been an increase in targeted awareness campaigns by both governmental and nongovernmental organizations. Programs such as the Ghana Health Service's *Adolescent Health Policy* and *Youth Corner Initiatives* have introduced school-based and community-based interventions that emphasize safer sexual practices, voluntary testing, and stigma reduction (GHS, 2023). Nonetheless, these campaigns often face sustainability challenges, especially in rural and peri-urban areas where cultural resistance and limited resources hinder behavioral change (Waisbord, 2018). These campaigns however barely cover non-sexual means of contracting STDS/STIs withing a community and how these transactions can be prevented within members of a community. When campaigns cover all means of transmission, it tends to curb the rate at which such diseases spread.

2.2 Conceptual Framework

2.2.1 Strategies for STI Prevention and Control

Globally, several strategies have been developed and implemented to prevent and control sexually transmitted infections (STIs), and these strategies are largely guided by the World Health Organization's (WHO) global health frameworks. The WHO (2022) outlines five key pillars of STI prevention: promotion of safer sexual behaviors, provision of high-quality condoms, use of

vaccines, expansion of testing and treatment services, and targeted interventions for key and vulnerable populations. Condom use remains one of the most effective and affordable means of preventing STIs when used consistently and correctly. Both male and female condoms serve as a physical barrier that significantly reduces the risk of transmission during sexual contact. Studies have shown that large-scale condom promotion campaigns, when integrated with public education and access programs, have led to measurable reductions in STI prevalence in sub-Saharan Africa and other low-resource settings (Unemo et al., 2023).

Behavioral and communication-based interventions form another critical dimension of STI prevention. These interventions focus on promoting safer sexual practices, delaying sexual debut among adolescents, and reducing multiple sexual partnerships. The WHO (2021) emphasizes that behavioral change programs must be community-driven, participatory, and tailored to local contexts to achieve sustained impact. Comprehensive sexuality education and targeted counseling have proven effective in increasing awareness and improving risk perception among youth and high-risk populations. A study published in *The Lancet Global Health* highlights that sustained behavior change communication—when combined with community dialogue and peer education—can effectively reduce risky sexual behaviors and improve condom use rates among adolescents and young adults (Tavrow & Withers, 2021).

Biomedical approaches also play a vital role in STI prevention. The introduction of vaccines such as the Human Papillomavirus (HPV) and Hepatitis B vaccines has significantly reduced the global burden of infections and related cancers (Chesson et al., 2020). The WHO (2022) further recommends voluntary medical male circumcision as an effective intervention for reducing the risk of HIV and other STIs among men. Additionally, innovations in diagnostic technologies—such as rapid testing kits and point-of-care diagnostics—have improved early detection and treatment, especially in low-resource environments. Partner notification and syndromic

management remain important in settings where laboratory facilities are limited, although challenges persist in ensuring complete treatment and follow-up (Rowley et al., 2019).

Community engagement and communication strategies are equally essential in bridging the gap between awareness and behavioral change. The WHO (2023) underscores those interventions which actively involve community leaders, peer educators, and faith-based organizations tend to have greater acceptance and sustainability. Such participatory approaches enhance trust, combat stigma, and promote open discussion about sexual health—particularly in conservative or rural communities. For example, research in Ghana and Kenya has shown that radio dramas, community theatre, and peer outreach programs can effectively normalize STI prevention conversations and encourage testing (Yirenya-Tawiah et al., 2020). These community-driven methods align closely with the principles of social and behavior change communication, emphasizing the role of cultural context and interpersonal influence in transforming attitudes and practices.

Finally, research and innovation remain vital components of global STI prevention efforts. Current scientific priorities include developing vaccines for gonorrhea and syphilis, combating antimicrobial resistance, and expanding the integration of STI services within primary healthcare systems (Newman et al., 2023). The WHO (2023) also calls for stronger monitoring and evaluation frameworks to track intervention outcomes and inform evidence-based policymaking. Collectively, these strategies form a comprehensive prevention model that integrates biomedical, behavioral, and structural approaches. For Ghana, this integrated framework is particularly relevant, as it highlights the need for culturally sensitive, community-based, and multi-channel communication strategies to reduce STI transmission. This understanding will be incorporated into the conceptual framework of this study, providing a global-to-local context for evaluating how communication strategies are deployed to influence sexual behavior and health outcomes.

2.2.2 Historical Trends

A historical overview of sexually transmitted diseases (STDs/STIs) reveals a long and evolving chronology shaped by changing epidemiology, scientific discovery, and shifting public-health responses. Records of syphilis date back to the late 15th century, when severe outbreaks were documented in Europe (Frith, 2013; Tampa et al., 2014), and the nineteenth and early twentieth centuries saw the identification and microbiological characterization of bacterial STIs such as gonorrhoea and the later recognition of chlamydial infections (Neisser, 1882; Jose, 2020; Centers for Disease Control and Prevention [CDC], 2022). Viral STIs — most notably HIV — emerged as a global public-health crisis in the early 1980s, reshaping research priorities, surveillance, and funding for infectious disease control (CDC, 2001; KFF, 2021; UNAIDS, 2023). Over the same period, improved laboratory diagnostics and molecular methods transformed the capacity to detect and monitor infections such as HSV and HPV, while the development and rollout of effective HPV vaccines in the 2000s created a major prevention breakthrough for oncogenic STI sequelae (Chesson et al., 2020; Jansen et al., 2023; Livescience/JAMA Pediatrics synthesis, 2025).

Global public-health responses accelerated after the HIV/AIDS crisis. WHO established large-scale programmes and guidance (e.g., Global Programme on AIDS, GHSS 2022–2030), and international financing mechanisms such as the Global Fund dramatically expanded access to antiretroviral therapy (ART) and prevention services in low- and middle-income countries (World Health Organization [WHO], 2022; Global Fund, 2024; Coovadia et al., 2005). These efforts contributed to steep reductions in AIDS-related mortality and new HIV infections in many settings (UNAIDS, 2023; The Global Fund, 2024). At the same time, global surveillance documented a persistent and large burden of curable STIs: WHO estimated roughly 374 million new cases of four curable STIs in 2020 (chlamydia, gonorrhoea, trichomoniasis and syphilis), highlighting that STI transmission remains intense despite HIV gains (WHO, 2022; Rowley et

al., 2019; Newman et al., 2023). Recent syntheses also underscore regional shifts — with new HIV infections increasingly concentrated outside sub-Saharan Africa in some years — even as pockets of high prevalence and vulnerability persist in African settings (UNAIDS, 2023; The Guardian reporting on 2024 trends).

In the last decade the epidemiological picture has become more complex. While HIV incidence has declined in many high-burden countries due to ART and prevention, bacterial STIs such as gonorrhoea and syphilis have shown resurgence in multiple regions, driven in part by antimicrobial resistance, reduced condom use, and service gaps (Rowley et al., 2019; Unemo et al., 2023; Narain, 2024). Antimicrobial resistance in Neisseria gonorrhoeae is now considered a major global threat with documented resistance to multiple drug classes, prompting updated WHO guidance and enhanced surveillance systems such as the CDC's GISP and WHO antimicrobial resistance alerts (Unemo et al., 2023; WHO, 2024; CDC GISP profiles, 2022). Concurrently, technological advances — rapid point-of-care tests, improved NAAT diagnostics, and expanded HPV vaccination — offer important countervailing forces that can reduce burden if deployed equitably (Newman et al., 2023; Chesson et al., 2020; Qin et al., 2022).

Ghana's experience mirrors many global patterns while reflecting local vulnerabilities. National data and surveys (GDHS, GHS reports) indicate that adolescents and young adults (roughly 15–34 years) bear a disproportionate share of STI incidence and symptoms, with gendered patterns that make adolescent girls particularly vulnerable (Ghana Statistical Service [GSS], 2023; Seidu et al., 2021; Ameyaw et al., 2022). Facility-based studies in Ghana document heavy use of syndromic management at primary care and pharmacy level, frequent self-medication, and limited laboratory confirmation — factors that contribute to under-ascertainment and recurrent infections (Hutton-Nyameaye et al., 2023; Nyameaye et al., 2023; Adanu et al., 2019). National programmes — including the Ghana AIDS Commission and the National STI/HIV Control

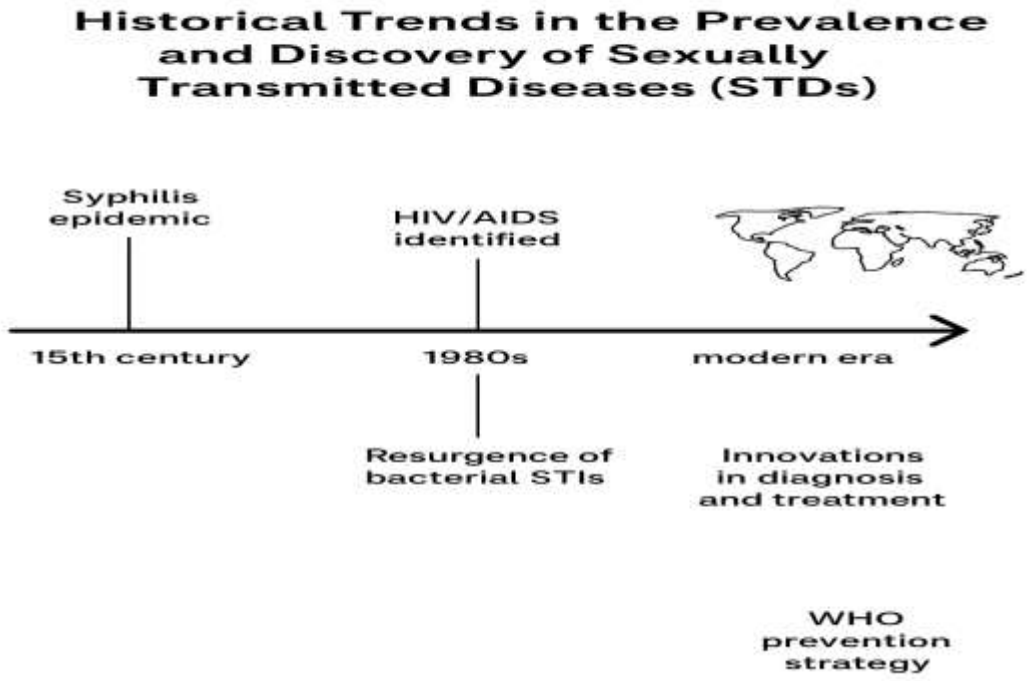
Programme — institutionalized prevention and treatment efforts from the 2000s onward, integrating behaviour-change communication, condom distribution, testing campaigns, and targeted outreach to key populations (Ghana Health Service, 2023; GAC strategic plans, 2021).

Recent Ghanaian and regional studies highlight persistent drivers of transmission: low and inconsistent condom use, early sexual debut and transactional sex in certain communities (notably fishing and peri-urban settlements), misinformation spread via peer networks and social media, and socioeconomic barriers to accessing testing and care (Owusu-Ansah et al., 2021; Mensah & Boadu, 2022; Doku & Addo, 2020; Appiah et al., 2023). Moreover, antimicrobial resistance concerns observed globally — including reduced susceptibility to cephalosporins and azithromycin — have implications for Ghanaian treatment protocols and demand strengthened surveillance and stewardship (WHO MDR gonorrhoea updates; Unemo et al., 2023; Tadesse et al., 2024). At the same time, community-level innovations (peer education, community theatre, radio dramas, and youth-focused interventions) have shown promise in improving knowledge and reducing stigma when they are sustained and culturally adapted (Panford et al., 2001; Yirenya-Tawiah et al., 2020; Ampofo et al., 2021).

Taken together, the historical trajectory of STIs — from the syphilis epidemics of the 15th century through microbiological discoveries in the 19th century to the HIV pandemic and 21st-century diagnostic and vaccine advances — demonstrates both progress and ongoing challenges (Frith, 2013; Neisser, 1882; CDC, 2001; WHO, 2022; UNAIDS, 2023). Contemporary public-health strategy therefore emphasizes combination prevention: biomedical interventions (vaccines, ART, VMMC), behavioural and social-change communication, improved diagnostics and partner services, and robust surveillance to detect antimicrobial resistance (WHO GHSS 2022–2030; Rowley et al., 2019; Newman et al., 2023). For Ghana, this history points to the urgent need for integrated, culturally sensitive communication strategies that address sexual and non-sexual

transmission routes, reduce stigma, strengthen care pathways, and incorporate genomic and resistance surveillance to guide effective treatment policies (Ghana Health Service, 2023; Hutton-Nyameaye et al., 2023; Unemo et al., 2023).

Figure 1.0: Historical Trends in the Prevalence and Discovery of Sexually Transmitted Diseases (STDs).



Source: Researcher's field data (2025)

2.2.3 Communication Strategies

Communication strategies refer to structured, evidence-based approaches designed to achieve specific behavioral or social objectives through the use of messages, media, and engagement channels (WHO, 2017). These strategies are fundamental in public health communication as they translate complex scientific information into accessible, actionable messages that guide communities toward positive behavioral outcomes (Schiavo, 2016; Obregon & Waisbord, 2019).

In health promotion, communication strategies are not merely about disseminating information but about fostering meaningful interaction between institutions and audiences (Airhihenbuwa, 2018). Effective strategies are grounded in theories of behavior change, including the Health Belief Model and the Social and Behavior Change Communication (SBCC) framework, which emphasize motivation, perceived risk, and self-efficacy (Storey et al., 2020). The World Health Organization (2017) asserts that strategic communication in health contexts aims to build trust, sustain engagement, and ensure that messages resonate across diverse demographic and cultural groups.

The effectiveness of communication strategies lies in their capacity to influence knowledge, attitudes, and behaviors over time. According to Rimal and Lapinski (2015), successful health communication goes beyond awareness creation—it facilitates behavior adoption through social reinforcement and community participation. Studies in Sub-Saharan Africa have shown that combining media campaigns with interpersonal communication leads to higher retention of preventive messages and improved adoption of health practices (Dutta, 2020; Tufte & Mefalopulos, 2017). Similarly, Figueroa et al. (2017) highlight those participatory approaches, which involve community dialogue and stakeholder collaboration, increase the perceived credibility of health interventions. Malikhao (2020) explains that the integration of audience-centered design, cultural sensitivity, and feedback mechanisms enhances message effectiveness, while Nutbeam and Bauman (2016) emphasize the need for continuous evaluation to measure both short-term and long-term behavioral outcomes.

In the context of sexually transmitted infections (STIs), communication strategies have evolved to reflect changes in both disease dynamics and communication technologies. Research indicates that multi-channel interventions—combining radio, television, peer education, and digital media—yield greater impact on preventive behaviors than single-channel approaches (Noar et al., 2017;

Kim et al., 2020). For instance, WHO (2018) reported that integrating interpersonal communication and media advocacy in STI campaigns led to increased testing uptake and condom use among youth populations. Rowley et al. (2019) found that sustained messaging emphasizing stigma reduction, partner communication, and testing contributed to a measurable decline in STI prevalence in some African countries. Unemo et al. (2021) further observed that targeted media interventions focusing on gender-specific messaging were effective in promoting awareness about antimicrobial resistance in gonorrhea. These findings demonstrate that strategic, diversified communication significantly influences STI control outcomes.

Moreover, the success of communication strategies depends heavily on contextual and structural factors such as literacy levels, access to media, and social norms. Evans et al. (2019) argue that behavioral outcomes are more likely when communication interventions are localized and culturally tailored. For example, campaigns in Ghana and Kenya that involved local opinion leaders and community-based theater achieved greater impact in promoting HIV testing and reducing stigma (Amegah & Rezza, 2019). Schiavo (2016) posits that audience segmentation—identifying distinct groups within a population—enables more precise targeting of messages. Similarly, Tufte and Mefalopulos (2017) note that adaptive communication frameworks, which evolve in response to audience feedback, sustain long-term engagement. This adaptability is crucial in addressing new challenges such as misinformation, digital fatigue, and pandemic-related communication barriers (Waisbord, 2020).

Finally, evaluating the effectiveness of communication strategies involves both quantitative and qualitative assessments. Nutbeam and Bauman (2016) recommend measuring exposure, message comprehension, attitudinal change, and behavioral adoption to determine impact. Dutta (2020) highlights that monitoring should also assess community participation and policy influence, as effective communication often leads to advocacy and systemic change. According

to Obregon and Waisbord (2019), communication evaluation must extend beyond campaign reach to include sustainability and empowerment indicators. Malikhao (2020) adds that digital platforms have expanded opportunities for real-time feedback, allowing implementers to refine messages based on audience interaction. Therefore, communication strategies are most effective when they are research-driven, culturally attuned, and continuously evaluated to align with evolving social realities and health priorities.

2.2.4 Communication Strategies for National Development

Communication strategies play a pivotal role in facilitating national development by shaping public behavior, mobilizing communities, and promoting participatory governance. In the context of health, education, and social policy, communication strategies enable governments and institutions to convey messages that influence awareness, knowledge, and behavior (WHO, 2017). These strategies are grounded in the understanding that effective communication can transform attitudes, reduce misinformation, and encourage civic participation (Tufte & Mefalopulos, 2017). According to Servaes (2016), national development is not only economic growth but also social progress, and communication serves as a bridge between policy intent and citizen engagement. When strategically designed, communication frameworks foster inclusivity and ensure that marginalized populations are not left behind in the development process (Obregon & Waisbord, 2019).

A key element of communication strategies for national development is their framework, which integrates planning, audience segmentation, message design, and media mix deployment (WHO, 2017). The communication framework emphasizes participatory approaches, evidence-based message formulation, and feedback mechanisms that ensure adaptability (Airhihenbuwa, 2018). Effective communication frameworks are cyclical—they begin with research and situation analysis, followed by strategy development, message dissemination, and evaluation (UNICEF, 2016).

Each phase ensures that interventions remain responsive to changing contexts and communication environments. As Piotrow et al. (2018) explain, the inclusion of multiple stakeholders—government, media, and civil society—enhances credibility and reach. These frameworks have become increasingly data-driven, using digital tools to measure behavioral outcomes and policy impacts (Dutta, 2020).

The stages and processes of communication strategies are fundamental to their success. According to the World Health Organization (2017), the process typically involves assessment, strategic design, implementation, monitoring, and evaluation. Each stage builds on the previous one to ensure coherence and continuity in messaging. In public health communication, for instance, strategic design includes audience research to understand cultural and social dynamics that affect message reception (Schiavo, 2016). Implementation then leverages interpersonal, community-based, and mass media channels to ensure broad and tailored outreach (Palen et al., 2020). Evaluation, as emphasized by Nutbeam and Bauman (2016), is essential for measuring both process and impact indicators—such as awareness, knowledge, and behavioral outcomes—which inform future improvements.

Communication strategies are implemented through coordinated actions that involve multiple sectors and stakeholders. In disease control, for example, governments and organizations deploy a mix of advocacy, social mobilization, and behavioral communication interventions (WHO, 2018). The success of campaigns against HIV/AIDS, malaria, and STDs demonstrates how effective communication can translate into improved health outcomes (UNAIDS, 2019). Social and Behavior Change Communication (SBCC) models have been widely adopted to guide interventions by combining interpersonal communication, community dialogue, and digital media outreach (Figueroa et al., 2017). Similarly, health promotion campaigns in Ghana, Nigeria, and Kenya have used localized messaging to encourage testing, condom use, and preventive

behaviors (Amegah & Rezza, 2019). Implementation therefore requires alignment between communication goals and national development priorities (CDC, 2018).

Finally, communication strategies contribute to national development by fostering transparency, accountability, and citizen empowerment. They enable governments to communicate reforms, promote behavioral change, and strengthen institutional trust (Servaes, 2016). In health systems, effective communication has been linked to improved compliance, reduced stigma, and increased uptake of preventive services (Palen et al., 2020). Beyond health, strategic communication supports education reforms, environmental conservation, and gender equality initiatives (Tufte & Mefalopulos, 2017). According to Waisbord (2020), sustainable development depends on participatory communication systems that value dialogue over dissemination. Thus, communication is not just a supportive tool—it is an enabler of inclusive, resilient, and informed societies.

2.2.5 Elements of a Communication Strategies Framework

A robust communication strategies framework is structured around five major components: audience segmentation, message design, media/channel selection, engagement and feedback mechanisms, and monitoring and evaluation. These elements collectively determine how effectively communication objectives are achieved in influencing health behavior and promoting public awareness. According to the World Health Organization (2017), these elements are essential for the design and execution of any strategic communication campaign, especially within the field of public health and disease prevention. The integration of these components creates a systematic and evidence-based approach that ensures messages are not only received but also understood, accepted, and acted upon by target populations (Briscoe & Aboud, 2022; Evans et al., 2025).

Audience segmentation is a foundational step in developing communication strategies, ensuring that messages are crafted for the right groups based on demographic, psychographic, behavioral, or epidemiological characteristics. In STI prevention campaigns, segmentation helps identify key populations such as adolescents, commercial sex workers, or men who have sex with men (MSM), who may have distinct communication needs and risk perceptions (Roberts et al., 2023; Noar et al., 2021). Tailoring communication to these groups has been shown to significantly enhance message relevance, retention, and behavioral outcomes (Schuh et al., 2025; Kim et al., 2024). Research by O'Leary and Storey (2017) also emphasizes that audience segmentation facilitates the allocation of resources toward high-impact interventions, ensuring cost-effectiveness and improved health outcomes.

Message design focuses on how content is created, framed, and delivered to influence attitudes and actions. Effective message design integrates clarity, emotional appeal, cultural sensitivity, and credible sources to increase acceptance (DePaula et al., 2022; Malikhao, 2020). Studies in health communication highlight that framing messages around social responsibility and empathy produces stronger behavioral shifts than fear-based appeals (Rimal & Lapinski, 2023; Evans et al., 2025). Moreover, the use of narrative-based or story-driven approaches has become increasingly popular in contemporary STI communication because stories are relatable and stimulate emotional engagement (Kim et al., 2024; Noar & Harrington, 2021).

Media and channel selection determines how effectively communication messages reach and engage the target audience. The diversity of media—ranging from traditional outlets such as radio and television to digital and social media platforms—requires a balanced mix for maximum impact (Briscoe & Aboud, 2022; WHO, 2017). Research shows that multichannel approaches outperform single-medium campaigns by reinforcing consistent messages across multiple touchpoints (DePaula et al., 2022; Roberts et al., 2023). In Ghana and other sub-Saharan African

contexts, the combination of radio talk shows, SMS alerts, and community theatre has been highly effective in STI prevention and health promotion (Mensah et al., 2021; Rowley et al., 2019).

Engagement and feedback mechanisms ensure that communication remains participatory and community-driven. Instead of one-way message dissemination, modern strategies emphasize dialogue, feedback loops, and community mobilization to build trust and co-create solutions (Malikhao, 2020; Schuh et al., 2025). This participatory model aligns with the principles of social and behavior change communication (SBCC), which positions communities as partners rather than mere beneficiaries (Rimal & Lapinski, 2023; Evans et al., 2025). Evidence from interventions in Kenya and South Africa shows that peer-led discussions and participatory community forums enhance self-efficacy and collective responsibility for STI prevention (Briscoe & Aboud, 2022; Roberts et al., 2023).

Finally, monitoring and evaluation (M&E) are integral to assessing communication effectiveness. This involves tracking process indicators (reach, exposure, engagement) and outcome indicators (behavioral change, infection rates) to guide program adaptation (WHO, 2017; Annual Review of Public Health, 2025). Continuous M&E allows for the identification of gaps, ensuring accountability and evidence-based adjustments in strategy implementation (Noar et al., 2021; Schuh et al., 2025). In STI control programs, M&E has facilitated the refinement of messages and the targeting of high-risk populations based on real-time data (Kim et al., 2024; Roberts et al., 2023).

2.2.6 Stages and Processes of Communication Strategies

Communication strategies unfold through four systematic stages: assessment, design and implementation, evaluation, and adaptation. Each stage is interconnected, forming a cyclical process that ensures communication remains evidence-based, responsive, and impactful. The World Health Organization (2017) and Evans et al. (2025) emphasize that these stages are essential for ensuring that interventions address real community needs while remaining flexible to evolving contexts. Through structured progression from situational analysis to adaptation, communication strategies achieve both behavioral and social change outcomes, particularly in health promotion and disease prevention campaigns (Rimal & Lapinski, 2023; Schuh et al., 2025).

Assessment, the first stage, focuses on understanding the health issue, audience characteristics, and environmental context before designing any communication intervention. This involves identifying the target population, analyzing socio-cultural norms, assessing media habits, and mapping key stakeholders (WHO, 2017; Briscoe & Aboud, 2022). Effective assessment provides a baseline for planning and ensures strategies are contextually grounded. In STI and HIV prevention, assessment tools such as knowledge-attitude-practice (KAP) surveys and focus group discussions are widely used to uncover behavioral barriers and communication gaps (Roberts et al., 2023; Kim et al., 2024). Recent studies highlight that data-driven audience profiling leads to more effective message design and resource allocation (Evans et al., 2025; Noar et al., 2021).

The design and implementation stage translates the insights gained from assessment into concrete communication plans. This includes setting communication objectives, designing and pretesting messages, selecting appropriate media channels, producing materials, and launching campaigns (Malikhao, 2020; Schuh et al., 2025). The design phase is guided by theoretical models such as the Health Belief Model and the Social Cognitive Theory, ensuring that messages resonate with

psychological and social determinants of behavior (Rimal & Lapinski, 2023; Evans et al., 2025). Implementation then operationalizes these designs through coordinated media releases, community outreach, or social media campaigns. For example, in Ghana's STI prevention initiatives, communication strategies often combine drama, peer education, and radio talk shows to reach diverse populations (Mensah et al., 2021; DePaula et al., 2022).

Evaluation represents the third stage, where the effectiveness of the communication strategy is systematically measured. Evaluation typically assesses three dimensions: process (the extent and fidelity of implementation), intermediate outcomes (changes in knowledge, attitudes, and intentions), and impact (behavioral change or disease reduction) (Annual Review of Public Health, 2025; WHO, 2017). Quantitative methods such as surveys, and qualitative approaches like interviews and focus groups, are used to triangulate findings. Schuh et al. (2025) emphasize that rigorous evaluation not only determines success but also informs accountability and learning. In STI campaigns, evaluating communication outcomes helps determine which messages and media channels produce the greatest influence on preventive behaviors (Roberts et al., 2023; Kim et al., 2024).

Finally, adaptation is the stage where findings from evaluations are used to refine, scale up, or redesign the communication strategy for greater effectiveness and sustainability (WHO, 2017; Evans et al., 2025). Continuous feedback loops allow health communicators to respond to emerging challenges, such as misinformation, resistance, or changes in disease patterns (Malikhao, 2020; Roberts et al., 2023). In many health programs, adaptive management ensures interventions remain relevant across time and contexts, particularly in dynamic environments affected by evolving public health crises (DePaula et al., 2022; Noar et al., 2021). This iterative process aligns with WHO's communication-for-health framework, which promotes flexibility

and learning as integral parts of communication success (WHO, 2017; Annual Review of Public Health, 2025).

The cyclical nature of these stages—moving from assessment to adaptation—illustrates that communication strategies are not static but living systems that evolve with their social and epidemiological environments. Effective communication for STI prevention, therefore, relies on integrating assessment insights, theory-based design, rigorous evaluation, and adaptive refinement (Schuh et al., 2025; Rimal & Lapinski, 2023). When systematically applied, this process enhances not only individual behavioral outcomes but also the collective resilience of public health systems in preventing and controlling disease transmission.

2.2.7 Implementation of Communication Strategies in Disease Control

Implementing communication strategies for disease control, particularly for sexually transmitted diseases (STDs) and infections (STIs), is a multidimensional process that translates theory into practical, coordinated public health action. Effective implementation requires strategic planning, institutional collaboration, and contextual adaptation. The World Health Organization (WHO, 2017) emphasizes that implementation must integrate the principles of the "Communicating for Health" framework—ensuring that communication is evidence-based, participatory, and inclusive. Coordination across sectors such as health, education, media, and local governance enhances message consistency and optimizes resource use (Barreto et al., 2024; Evans et al., 2025). For example, in Ghana, partnerships between the Ghana Health Service (GHS), Ghana AIDS Commission, and civil society organizations have created synergy in executing HIV and STI prevention campaigns, ensuring that national and local communication efforts reinforce each other (Mensah et al., 2021; Roberts et al., 2023).

A core aspect of implementation is capacity building, which ensures that communicators, health professionals, and peer educators possess the knowledge, attitudes, and skills required to effectively engage target populations. Training initiatives for media practitioners, healthcare providers, and youth volunteers enhance message delivery, accuracy, and cultural sensitivity (Kim et al., 2024; Annual Review of Public Health, 2025). Capacity building is particularly crucial in resource-constrained environments, where health literacy and technical expertise may vary across communities (Schuh et al., 2025; Malikhao, 2020). Studies show that programs that invest in sustained capacity building achieve higher audience trust and message retention rates (DePaula et al., 2022; Briscoe & Aboud, 2022). Moreover, integrating interpersonal skills training into communication planning helps ensure that health workers can tailor messages to specific audiences, such as adolescents or key populations at higher risk of STDs (Rimal & Lapinski, 2023; Roberts et al., 2023).

At the community level, implementation often involves localized and participatory communication channels such as community theatre, peer education, radio drama, and advocacy sessions. These strategies ground health messages in the lived realities of communities, enhancing cultural resonance and collective ownership (Panford et al., 2001; Yirenya-Tawiah et al., 2020). In Ghana, for instance, radio dramas and storytelling sessions in local languages have been used effectively to address myths surrounding HIV and STIs while promoting voluntary testing and treatment adherence (Mensah et al., 2021; DePaula et al., 2022). Community participation not only improves message credibility but also creates sustained behavioral reinforcement through social networks (Evans et al., 2025; Roberts et al., 2023). According to WHO (2017), community-driven interventions are essential in overcoming cultural resistance and stigma—two significant barriers to STI prevention and treatment in low- and middle-income countries.

In recent years, digital and social media platforms have become powerful tools in the implementation of communication strategies for disease control. Digital campaigns leverage the interactive nature of platforms such as Facebook, WhatsApp, Instagram, and TikTok to engage young and mobile populations (Kim et al., 2024; DePaula et al., 2022). These campaigns provide real-time information, promote safe-sex practices, and encourage testing through online counseling and clinic locators (Schuh et al., 2025; Annual Review of Public Health, 2025). Studies show that integrating traditional media with digital outreach significantly enhances reach and recall, particularly among youth who are often difficult to engage through conventional channels (Noar & Harrington, 2021; Roberts et al., 2023). In Ghana and other African contexts, hybrid approaches that blend interpersonal, broadcast, and digital communication have been especially successful in bridging awareness gaps and promoting early treatment-seeking behaviors (Yirenya-Tawiah et al., 2020; Mensah et al., 2021).

Finally, successful implementation in STD/STI control often combines communication interventions with tangible public health services. Campaigns integrate messaging with condom distribution, voluntary HIV testing, partner notification, and education on non-sexual transmission routes (Rowley et al., 2019; Unemo et al., 2023). These integrated approaches have proven effective in increasing risk perception and preventive behavior while reducing stigma associated with STDs/STIs (Evans et al., 2025; Roberts et al., 2023). For example, WHO-led regional STI programs in sub-Saharan Africa emphasize a "communication plus service" model, where messages are immediately linked to accessible testing or treatment services (WHO, 2017; Barreto et al., 2024). The success of such programs lies in their ability to connect information to action, ensuring that communication not only informs but also empowers individuals and communities to make health-promoting decisions.

Implementing communication strategies in public health, especially for disease prevention, often encounters multiple challenges that affect their effectiveness and sustainability. Among the most persistent obstacles are limited financial and human resources, which restrict the scope and frequency of campaigns (WHO, 2017; Evans et al., 2025). Additionally, media saturation and message fatigue—where audiences are overwhelmed by competing messages—reduce attention and engagement levels (Barreto et al., 2024; Schuh et al., 2025). Low health literacy, especially in marginalized populations, further hinders comprehension and message internalization (Kim et al., 2024; Roberts et al., 2023). Cultural taboos surrounding sensitive topics such as sexually transmitted infections often impede open dialogue, while distrust in public institutions can lead to skepticism about official communication (Malin & Lapinski, 2023; Annual Review of Public Health, 2025). These barriers collectively weaken message uptake and behavior change outcomes.

To mitigate these barriers, key enablers of successful communication strategy implementation have been identified. One major enabler is stakeholder involvement across all stages—design, delivery, and evaluation—which fosters ownership and contextual relevance (WHO, 2017; Roberts et al., 2023). Similarly, community participation and use of trusted local voices—such as religious leaders, traditional authorities, or community health workers—enhance credibility and resonance (Kim et al., 2024; Barreto et al., 2024). Transparency in messaging and decision-making processes also builds public trust and reduces resistance to interventions (Evans et al., 2025; Malikhao, 2020). Furthermore, adaptive monitoring systems that allow real-time feedback and quick modifications to campaigns ensure that messages remain relevant and effective in rapidly changing contexts (WHO, 2017; Schuh et al., 2025).

Best practices in communication implementation emphasize message clarity, cultural sensitivity, and audience-centeredness. Messages should be simple, actionable, and contextually relevant to

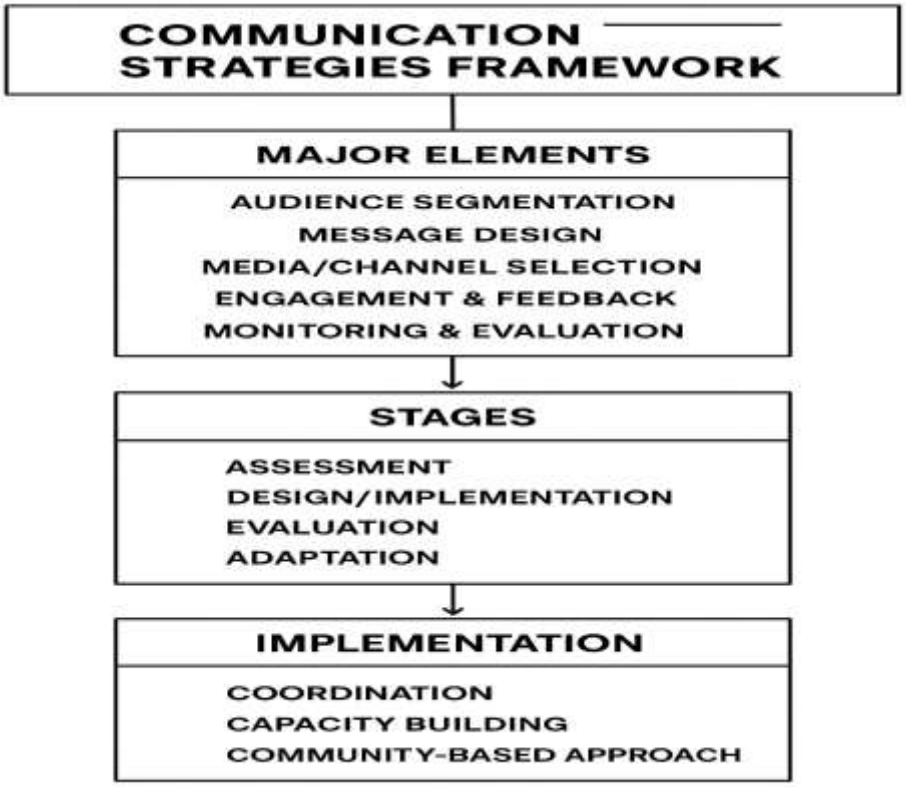
the target audience (Annual Review of Public Health, 2025; Roberts et al., 2023). For example, successful health communication interventions often combine mass media (television, radio, digital) with interpersonal channels (community meetings, peer educators) to maximize both reach and depth (Kim et al., 2024; DePaula et al., 2022). Evidence from WHO (2017) suggests that integrated approaches—where media messages reinforce interpersonal communication—are more effective at promoting behavioral change than isolated campaigns. In addition, timing and frequency of messages should be optimized to maintain engagement without causing fatigue (Schuh et al., 2025; Evans et al., 2025).

Another best practice lies in ensuring multi-sectoral collaboration and decentralization of implementation. Partnerships between government agencies, civil society, and media organizations increase efficiency and credibility, particularly when communication is localized (Barreto et al., 2024; Kim et al., 2024). Moreover, capacity building for communicators and health educators strengthens delivery quality and consistency across platforms (Roberts et al., 2023; WHO, 2017). Engaging local institutions and media outlets further promotes sustainability by embedding interventions within existing community structures. These collaborative approaches have been shown to yield longer-term impacts compared to top-down campaigns (Annual Review of Public Health, 2025; Malin & Lapinski, 2023).

Finally, integrating structural and behavioral interventions has emerged as a hallmark of modern public health communication. Communication alone is insufficient if social determinants such as poverty, gender inequality, and access to healthcare remain unaddressed (Evans et al., 2025; Barreto et al., 2024). Therefore, the most effective strategies are those that combine communication with policies improving social conditions and access to services (Kim et al., 2024; WHO, 2017). Such multi-level approaches not only change individual behavior but also transform the environments that shape it (Schuh et al., 2025; Roberts et al., 2023). In essence,

best practices in communication strategy implementation rely on adaptive, inclusive, and evidence-based frameworks that respond dynamically to audience needs and contextual realities.

Figure 2.0: Communication Strategies Framework



Source: Researcher's Field Data (2025)

2.2.8 Analysis of Diagram

The "Communication Strategies Framework" table presents a systematic structure that outlines how health communication interventions—particularly in STD/STI prevention—are conceptualized, implemented, and evaluated. Each element in the table represents a critical stage that collectively contributes to achieving behavioral change and improving public health outcomes. The table demonstrates a process-oriented flow, beginning with situation assessment, followed by strategic design, implementation, and ending with evaluation and adaptation. This

cyclical process reflects a feedback-driven model that ensures communication remains dynamic, evidence-based, and responsive to evolving public health needs (WHO, 2017; Evans et al., 2025).

The assessment stage focuses on diagnosing the communication environment—identifying the target audience, understanding cultural beliefs, assessing health literacy, and mapping behavioral determinants. This step is fundamental to ensuring interventions are grounded in real contexts rather than assumptions (Kim et al., 2024; Malikhao, 2020). For instance, in STD/STI control, situational analyses often reveal barriers such as stigma, misinformation, and inconsistent condom use, allowing messages to be customized accordingly (Rowley et al., 2019; Unemo et al., 2023). By anchoring strategies in data and social context, this phase enhances message relevance and cultural sensitivity, both of which are central to behavior modification.

The design and implementation stage are the operational heart of the framework. It involves developing, testing, and disseminating messages through a mix of channels—ranging from community radio and peer outreach to digital and mass media campaigns (DePaula et al., 2022; Schuh et al., 2025). The design process ensures that messages are audience-specific, actionable, and persuasive, using culturally resonant narratives and credible messengers. In Ghana, for instance, local drama, radio storytelling, and youth-led outreach have proven highly effective in demystifying STIs and promoting testing (Yirenya-Tawiah et al., 2020; GHS, 2022). Implementation also emphasizes coordination across sectors—health, education, and media—creating synergy between institutional and community-level actions (Barreto et al., 2024).

The evaluation and adaptation stage ensures accountability and sustainability. Here, communication outcomes are assessed against intended objectives—such as improved awareness, increased testing, and reduction in risky behaviors (WHO, 2017; Roberts et al., 2023). Evaluation methods include tracking message reach, behavioral indicators, and feedback from communities to determine what worked and what needs refinement. The adaptation element

then closes the loop by feeding evaluation findings into new strategic cycles, ensuring continuous learning and relevance (Annual Review Public Health, 2025; Evans et al., 2025). In the context of STD/STI control, such iterative adaptation is crucial to counter emerging challenges like antimicrobial resistance and changing sexual behavior trends (Unemo et al., 2023; Kim et al., 2024).

Overall, the elements in the communication strategies framework table contribute to the study by offering a blueprint for evaluating how media and interpersonal channels interact to drive social and behavioral change. The framework's structure aligns with the study's objective of assessing the effectiveness of media mix communication strategies in influencing social security enrollment and STD/STI prevention among Ghana's self-employed population. It provides a methodological foundation for examining not only the content and reach of messages but also their capacity to foster trust, reshape norms, and sustain behavior change (Malikhao, 2020; Rowley et al., 2019; WHO, 2023).

2.3. Theoretical Framework

2.3.1 Health Belief Model (HBM)

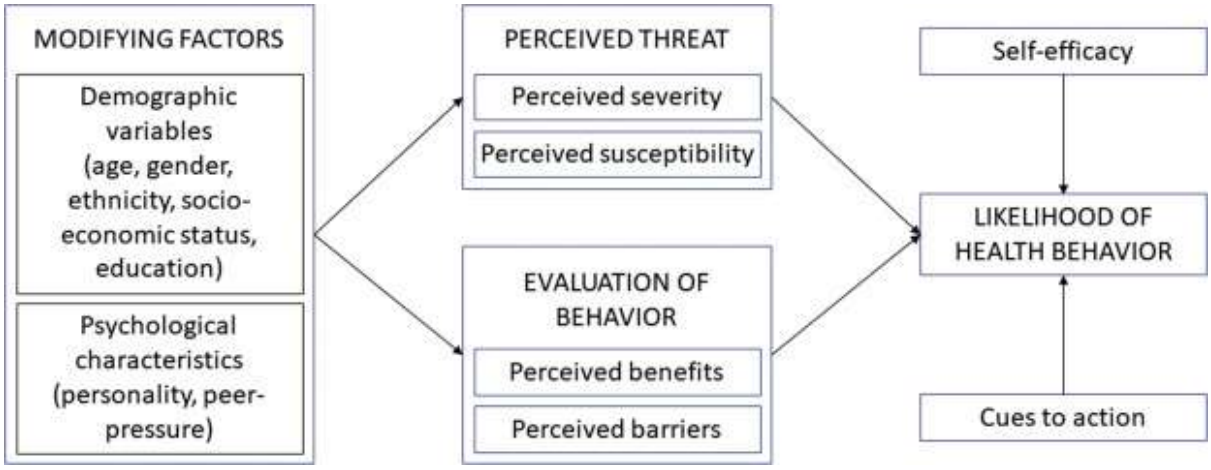
The Health Belief Model (HBM) is one of the most widely applied behavioral theories in public health communication. Developed in the 1950s, it emphasizes that individuals' readiness to act depends on their perceptions of health risks and the benefits of taking preventive measures (Rosenstock, 1974; Champion et al., 2020). In the context of social security enrollment for self-employed workers in Ghana, the model provides a basis for analyzing how perceptions of vulnerability—such as the risk of poverty or income insecurity in old age—shape individuals' decisions to engage with social protection programs.

HBM identifies six core constructs: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Carpenter, 2010). For example, self-employed workers who feel highly susceptible to financial insecurity in retirement and perceive enrollment as beneficial are more likely to participate. However, perceived barriers such as lack of trust in government, affordability, or bureaucratic complexity can hinder action. These constructs provide a systematic framework for evaluating how media campaigns address both motivators and obstacles to behavioral change.

Recent applications of HBM in health and social campaigns demonstrate its relevance. Studies show that communication strategies that highlight personal risk and emphasize practical benefits are more effective in encouraging preventive behaviors (Janz & Becker, 2019; Orji et al., 2021). In Ghana, messages that underscore the severity of economic challenges without social security, while providing cues such as testimonials from peers who enrolled, can increase self-employed workers' willingness to act.

Importantly, HBM also accounts for the role of self-efficacy. For instance, campaigns that build confidence in navigating the enrollment process—by simplifying procedures or using trusted local agents—can enhance participation (Jones et al., 2022). This aspect aligns with the study's focus on evaluating not only media exposure but also how campaigns empower individuals to act.

Figure 6.0: Health Belief Model



Source: Springer, (2023)

Analysis of the Health Belief Model (HBM) Diagram

The Health Belief Model (HBM) remains one of the most influential theoretical frameworks for understanding and predicting health-related behaviours. Developed by Rosenstock (1974) and later refined by Becker and colleagues, the HBM posits that individuals' engagement in preventive health behaviour is determined by their beliefs about susceptibility, severity, benefits, and barriers, as well as cues to action and self-efficacy (Janz & Becker, 1984; Glanz et al., 2015). This model has been extensively applied in disease prevention campaigns, including sexually transmitted infections (STIs), HIV/AIDS, and other communicable diseases. It offers a structured framework for analyzing why individuals decide to take or avoid preventive actions despite having access to information. In the context of Ghana, where cultural norms, stigma, and misinformation often shape sexual health practices, the HBM provides a useful basis for assessing how communication strategies can foster awareness, motivation, and behavioural change among populations (Amu & Nyarko, 2019; Appiah-Agyekum et al., 2023).

2.3.2 Modifying Factors

Modifying factors are the background variables that influence individuals' health perceptions and decisions. These include demographic factors (age, sex, education, income), sociopsychological factors (peer influence, cultural values, stigma), and structural factors such as access to health services (Glanz et al., 2015; Carpenter, 2010). In STI prevention, these factors are critical in shaping individual and community-level attitudes toward testing, treatment, and disclosure. For example, younger populations in Ghana may have better access to social media-based sexual health campaigns but lower perceived severity, while older adults may face stigma and cultural barriers (Appiah-Agyekum et al., 2023). Socioeconomic status also plays a significant role; individuals with lower income or education may face more perceived barriers to accessing care, even when awareness is high (Boateng et al., 2022).

Moreover, modifying factors such as religion, gender norms, and social expectations influence the communication of sexual health information. Studies in sub-Saharan Africa indicate that women often perceive higher susceptibility to STIs but are constrained by power imbalances that limit their ability to insist on condom use (Amegah et al., 2020; Yakubu et al., 2022). Therefore, effective communication strategies must consider these contextual factors, tailoring messages and delivery channels to different audience groups. In this sense, the HBM reinforces the principle of audience segmentation—a key element in communication strategy frameworks (WHO, 2017; Briscoe & Aboud, 2022).

2.3.2.1 Perceived Susceptibility

Perceived susceptibility refers to an individual's belief in their likelihood of contracting a disease or health condition (Rosenstock, 1974; Janz & Becker, 1984). It is one of the strongest predictors of health behaviour because people who perceive themselves as vulnerable are more likely to

take preventive action. In STI prevention campaigns, increasing perceived susceptibility is crucial, particularly among youth who often underestimate their risk (Yakubu et al., 2022; Edem, 2018). Research in Ghana shows that many young adults engage in risky sexual practices despite awareness of HIV and STIs, reflecting a gap between knowledge and perceived personal vulnerability (Amu & Nyarko, 2019).

To address this, communication strategies must include targeted messages that personalize risk perception. For example, mass media campaigns featuring relatable testimonies or dramatized stories can make the threat of STIs more tangible (Evans et al., 2025; Kim et al., 2024). According to Malikhao (2020), integrating emotional narratives and real-life experiences enhances the salience of health messages, prompting individuals to reassess their vulnerability. Additionally, social media campaigns that use peer influencers have been shown to significantly improve risk perception among adolescents and young adults (Roberts et al., 2023). In the Ghanaian context, community-based sensitization that links local realities with risk factors—such as multiple sexual partnerships or untreated infections—has proven effective in reshaping perceived susceptibility (Yirenya-Tawiah et al., 2020).

2.3.2.2 Perceived Severity

Perceived severity denotes an individual's assessment of the seriousness of a disease and its potential consequences (Glanz et al., 2015). When individuals recognize the severe health, social, or economic implications of a condition, they are more likely to adopt preventive measures. In the case of STIs, perceived severity encompasses concerns about infertility, social stigma, chronic pain, and increased risk of HIV transmission (Carpenter, 2010; Dutta, 2008). However, if individuals view an infection as easily curable or socially trivial, they may disregard preventive behaviours.

Health communication plays a vital role in shaping perceived severity through educational campaigns that explain the long-term complications of untreated STIs (WHO, 2023; Rowley et al., 2019). In Ghana, for instance, the National AIDS Control Programme has combined radio drama, community dialogues, and testimonial stories to highlight not only medical outcomes but also the social and psychological burden of infections (GHS, 2022). However, excessive use of fear appeals can backfire by creating anxiety or denial rather than positive action (Noar et al., 2017). Therefore, effective communication balances threat perception with efficacy cues—showing that prevention and treatment are accessible and effective (Schuh et al., 2025).

2.3.2.3 Perceived Benefits

Perceived benefits are the individual's beliefs in the value or effectiveness of taking a particular action to reduce risk or impact (Champion & Skinner, 2008). In STI prevention, this refers to how individuals perceive the benefits of using condoms, getting tested, or maintaining monogamous relationships. People are more likely to act when they believe the benefits outweigh the costs (Glanz et al., 2015). In Ghana, studies show that awareness of benefits is often high, but the perceived importance varies across demographics and education levels (Appiah-Agyekum et al., 2023).

Communication strategies must therefore demonstrate tangible and immediate benefits. Campaigns that emphasize maintaining reproductive health, protecting family well-being, or avoiding financial burdens from treatment are particularly persuasive (Evans et al., 2025; Kim et al., 2024). Moreover, highlighting social and emotional benefits—such as trust and respect from partners—can be equally powerful motivators (Malikhao, 2020). Evidence suggests that interventions combining mass media with interpersonal counseling significantly increase perceived benefits and sustained condom use among high-risk populations (Barreto et al., 2024; Roberts et al., 2023).

2.3.2.4 Perceived Barriers

Perceived barriers are the obstacles that hinder individuals from adopting a health behaviour, including financial, psychological, or cultural factors (Rosenstock, 1974; Janz & Becker, 1984). In STI control, these may include fear of stigma, partner disapproval, embarrassment, lack of confidentiality, or misconceptions about treatment side effects (Amegah et al., 2020; Unemo et al., 2023). High perceived barriers often neutralize the impact of knowledge and awareness.

Effective communication strategies must address and minimize these barriers through evidence-based interventions. For instance, community-based education programmes that normalize STI testing and emphasize confidentiality can mitigate stigma (Panford et al., 2001; WHO, 2023). Additionally, integrating STI services into broader reproductive health programmes can reduce psychological resistance (Yirenya-Tawiah et al., 2020). In digital spaces, chat-based counseling and anonymous information platforms have been shown to overcome fear of exposure (DePaula et al., 2022). Reducing logistical and social barriers is critical to translating awareness into action and ensuring sustained behaviour change (Evans et al., 2025).

2.3.2.5 Cues to Action

Cues to action are triggers that motivate individuals to engage in health-promoting behaviour. They may be internal, such as experiencing symptoms, or external, such as public campaigns, interpersonal messages, or policy initiatives (Glanz et al., 2015; Champion & Skinner, 2008). Cues are essential because awareness alone rarely leads to action; individuals often need reminders or incentives. In Ghana, radio and community announcements about free STI testing days, mobile health fairs, or peer education sessions act as effective cues to action (Appiah-Agyekum et al., 2023; GHS, 2022).

Innovative digital interventions, including SMS reminders and social media nudges, have also demonstrated strong results in increasing HIV testing uptake and condom use (Kim et al., 2024; Roberts et al., 2023). According to the WHO (2017), cues must be strategically timed and culturally relevant, ensuring that individuals are motivated when access to services is feasible. When coupled with visual or interpersonal reinforcement, cues transform passive awareness into practical engagement (Schuh et al., 2025).

2.3.2.6 Self-Efficacy

Self-efficacy, added later to the HBM by Bandura (1997), refers to an individual's confidence in their ability to perform the recommended health behaviour. It is a critical determinant of whether individuals sustain preventive actions even in challenging environments (Glanz et al., 2015). In STI prevention, self-efficacy encompasses confidence in negotiating condom use, seeking testing, or discussing sexual health openly (Champion & Skinner, 2008).

Interventions that include skill-building components—such as role-play, peer mentoring, or counseling—are effective in enhancing self-efficacy (Evans et al., 2025). In Ghana, peer-education programmes and participatory workshops led by NGOs have been shown to significantly improve communication skills and negotiation capacity among youth and women (Amegah et al., 2020; Yirenya-Tawiah et al., 2020). Moreover, media campaigns that depict relatable individuals successfully overcoming barriers contribute to modelling confidence and reinforcing self-belief (Malikhao, 2020; Roberts et al., 2023). Strengthening self-efficacy ensures that individuals maintain preventive practices even when external support or reinforcement declines.

2.3.3 Likelihood of Action and Behavioural Adoption

The likelihood of action in the HBM results from the dynamic interaction between all constructs—susceptibility, severity, benefits, barriers, cues to action, and self-efficacy (Janz &

Becker, 1984). Behavioural change occurs when perceived threat is high, benefits outweigh barriers, cues are timely, and individuals feel capable of taking action. In STI prevention, this means that individuals must simultaneously recognize personal risk, appreciate the seriousness of infection, trust in preventive measures, and feel empowered to act (Glanz et al., 2015; Evans et al., 2025).

Health communication interventions grounded in the HBM have shown remarkable success in improving behavioural outcomes globally and in Ghana (Appiah-Agyekum et al., 2023; GHS, 2022). By systematically addressing all model components, these strategies move beyond awareness creation to actual behavioural modification—promoting consistent condom use, testing, and treatment adherence.

2.3.4 Diffusion of Innovation (DOI) Theory

The Diffusion of Innovation (DOI) theory, introduced by Everett Rogers, explains how new ideas, behaviors, or technologies spread within a social system over time (Rogers, 2003). It posits that adoption follows a process influenced by communication channels, social systems, time, and the perceived attributes of the innovation itself. In the context of this study, the DOI theory provides a valuable framework for understanding how communication strategies promote the adoption of social security enrollment among Ghana's self-employed workers.

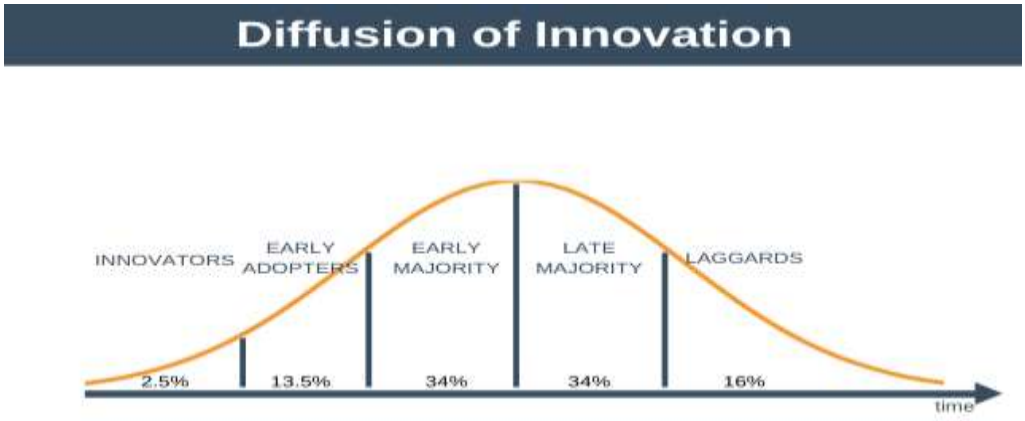
One of the central features of the DOI theory is the categorization of adopters into innovators, early adopters, early majority, late majority, and laggards (Greenhalgh et al., 2017). Each group responds differently to communication strategies, which implies that a successful media mix must segment audiences and tailor messages to meet their varying levels of readiness. For instance, digital media platforms may appeal to younger, more technologically inclined early adopters,

while interpersonal or community-based strategies may resonate better with the late majority and laggards.

DOI also identifies key attributes that influence adoption: relative advantage, compatibility, complexity, trialability, and observability (Rogers, 2003; Dearing & Cox, 2018). In the case of Ghana's social security campaign, messages must highlight the relative advantage of enrollment (e.g., financial security in old age), ensure compatibility with cultural and social norms, and reduce complexity by simplifying enrollment processes. Opportunities for trialability, such as flexible contribution schemes, and observability, through visible testimonies of beneficiaries, also play critical roles in diffusion.

Recent studies demonstrate that the DOI framework is effective in evaluating social and behavioral change campaigns. For example, it has been applied to health interventions, climate change awareness, and financial inclusion programs to assess how innovations diffuse across communities (Chou & Feng, 2019; Mutalemwa, 2020). In Ghana, the same logic applies to social security enrollment, where trust, peer influence, and visible benefits are essential to accelerating adoption.

Figure 7.0: Diffusion of Innovations Theory



Source: Rogers, (2003)

Analysis of the Diffusion of Innovations Theory Diagram

The Diffusion of Innovation (DOI) theory developed by Everett Rogers (1962, 2003) explains how new ideas, practices or technologies spread within a social system over time. The model assumes that individuals adopt innovations at different rates, influenced by factors such as communication channels, social networks, perceived benefits and compatibility with cultural values (Rogers, 2003; Greenhalgh et al., 2017). The theory is visually represented as a bell-shaped curve that categorized adopters into five distinct groups: Innovators, Early Adopters, Early Majority, Late Majority and the Laggards. Each group plays a unique role in the process of spreading and normalizing new behaviours or ideas. In public health communication-especially in campaign targeting disease prevention such as HIV/AIDS or STI control–DOI framework helps practitioners understand audience readiness and tailor communication strategies in different adopter categories (Valente & Roger, 2017; Kim et al., 2024).

Innovators constitute the smallest proportion of the population—typically around 2.5%—and represent the first individuals to adopt a new idea or technology (Rogers, 2003). They are characterized by high levels of education, curiosity, risk-taking, and social mobility (Greenhalgh et al., 2017). In health communication contexts, innovators are often health professionals, researchers, or influential community members who are open to experimenting with new health interventions before others. Their adoption decisions are not solely influenced by social norms but by intrinsic motivation to explore novelty and potential benefits (Valente, 2017).

In the fight against sexually transmitted infections, innovators might include early participants in pilot programmes promoting new STI testing methods, digital health tools, or behavioural change campaigns (Schuh et al., 2025). For example, in Ghana, early health educators and NGOs that first integrated mobile-based HIV awareness messages in rural areas acted as innovators—testing

new communication modes before scaling up (Amegah et al., 2020). Their willingness to take risks enables early data collection, identification of challenges, and demonstration of feasibility, laying the foundation for wider community adoption (Kim et al., 2024).

The Early Adopters, accounting for roughly 13.5% of the population, are critical opinion leaders and social influencers who observe the success of innovators before embracing an innovation themselves (Rogers, 2003; Valente, 2017). They are often respected within their communities and play a bridging role between innovators and the broader public. Early adopters interpret and contextualize innovations, translating technical or abstract concepts into culturally meaningful language for their peers (Greenhalgh et al., 2017).

In health communication, early adopters are essential in legitimizing new behaviours and setting social norms. In STI prevention, they might be religious leaders, teachers, peer educators, or media personalities who endorse condom use or advocate for regular testing after witnessing successful cases (Evans et al., 2025). According to Malikhao (2020), once early adopters begin promoting a behaviour publicly, others perceive it as socially acceptable and beneficial. Therefore, public health programmes often target this group through strategic partnerships, advocacy training, and tailored communication materials. Their visible endorsement creates trust and momentum, making it easier for the next group—the early majority—to follow (Kim et al., 2024).

Representing about 34% of the population, the early majority adopt innovations once they have been tested and proven effective by earlier groups (Rogers, 2003). This group is deliberate and pragmatic, requiring concrete evidence of success and reassurance of safety before committing (Valente, 2017). In health campaigns, the early majority is often influenced by both interpersonal communication and visible community outcomes. For instance, they may begin to seek STI

testing or use condoms regularly after observing positive testimonies from peers or local role models (Roberts et al., 2023).

In the Ghanaian context, this group corresponds to the larger segment of the population reached through mass media and community engagement programmes after initial pilot phases. The credibility of early adopters plays a crucial role in influencing them. As Evans et al. (2025) explain, behavioural diffusion accelerates when social proof and evidence-based communication are combined. The early majority's participation marks the transition from novelty to normalization—turning health innovations into common practice. Effective communication strategies during this phase must therefore emphasize practical benefits, social approval, and ease of participation (Kim et al., 2024).

The Late Majority, which also constitutes about 34% of the population, tends to adopt new ideas only after the majority of society has accepted them (Rogers, 2003; Greenhalgh et al., 2017). This group is typically skeptical, cautious, and motivated by peer pressure or institutional mandates rather than enthusiasm. They often require clear social validation and may respond more effectively to normative appeals or policy enforcement than persuasive messaging (Valente & Rogers, 2017).

In STI communication campaigns, the late majority might include individuals who are aware of preventive measures but remain hesitant due to cultural taboos, misinformation, or limited access to services (Amegah et al., 2020). When health innovations such as routine HIV testing become institutionalized—offered through national health facilities or school programmes—members of this group begin to participate (WHO, 2023). Therefore, strategies targeting this phase must rely on reinforcement through authority figures, policy integration, and visible community-wide benefits. Once this group joins, behavioural diffusion reaches its peak, creating the appearance of a "social tipping point" (Evans et al., 2025).

Laggards, making up the final 16% of the population, are the last to adopt an innovation known as the laggards. They are often isolated, older, less educated, and deeply embedded in traditional or resistant cultural frameworks (Rogers, 2003). Laggards tend to distrust change and authority, valuing stability and familiarity (Greenhalgh et al., 2017). In public health, this group is the most resistant to adopting preventive measures, often perceiving them as unnecessary or contrary to cultural norms.

For instance, in STI prevention, laggards may avoid testing, condom use, or sexual health discussions altogether due to stigma, fatalistic beliefs, or misinformation (Appiah-Agyekum et al., 2023; Yirenya-Tawiah et al., 2020). Addressing this group requires long-term, empathetic, and community-led approaches that build trust and emphasize relevance rather than urgency (Schuh et al., 2025). Peer mentorship, local language media, and repeated exposure through interpersonal communication are effective strategies to gradually shift their perceptions. Although laggards adopt change slowly, their eventual acceptance signifies the completion of the diffusion process and ensures sustainability within the social system (Kim et al., 2024).

2.3.5 Relevance to Behavioural Change and Communication

Overall, the Diffusion of Innovations Theory illustrates how behaviour change spreads progressively through society. In the context of disease prevention and health communication, understanding these adopter categories enables practitioners to design phased interventions—starting with innovators and early adopters to create credibility, before scaling outreach to the majority through social proof and reinforcement (Valente, 2017; Kim et al., 2024). The model emphasizes that change is both social and communicative, relying not only on message design but also on timing, trust, and social influence. When effectively applied, it helps bridge the gap between awareness and sustained behavioural adoption, making it particularly valuable in

designing STI/STD communication strategies in Ghana and across sub-Saharan Africa (Evans et al., 2025; WHO, 2023).

2.4. Relevance of the Theories to the Study

The Health Belief Model (HBM) is directly relevant to this study as it provides a framework for understanding how self-employed workers in Ghana perceive their susceptibility to social and financial insecurity in old age, and how such perceptions influence their decision to enroll in social security schemes. Central to HBM are constructs such as perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Champion et al., 2020). In this context, self-employed individuals may underestimate their vulnerability to financial insecurity or overestimate the barriers—such as affordability or bureaucratic processes—associated with enrolment. The study's assessment of communication strategies, therefore, aligns with HBM by examining whether media messages sufficiently highlight susceptibility and severity while promoting benefits and reducing perceived barriers.

HBM is also important because it draws attention to the role of cues to action, such as targeted campaigns, peer influence, and interpersonal communication, in prompting behaviour change (Carpenter, 2019). The present study explores how different media channels provide these cues and whether they are persuasive enough to motivate the self-employed to register for social security. This underscores the relevance of communication not only as a means of providing information but as a trigger for actual enrolment behaviour. Thus, HBM allows the study to critically evaluate if campaigns go beyond raising awareness to influencing tangible decisions.

Furthermore, the model's emphasis on self-efficacy is relevant to understanding whether communication campaigns empower individuals with the confidence and knowledge required to act. Self-employed workers may be aware of social security benefits but still doubt their ability to

navigate registration processes. This study's evaluation of communication strategies, therefore connects with HBM by examining whether messages address empowerment and provide practical guidance. The theory thus provides a comprehensive psychological lens for assessing communication effectiveness. On the other hand, the Diffusion of Innovation (DOI) Theory is equally crucial as it explains how new ideas, practices, or products—such as social security enrolment—are adopted over time within a population (Rogers, 2003; Greenhalgh et al., 2019). DOI identifies categories of adopters (innovators, early adopters, early majority, late majority, and laggards) and highlights how characteristics of an innovation—relative advantage, compatibility, complexity, trialability, and observability—affect adoption. In this study, DOI helps analyse how communication strategies influence adoption patterns among self-employed workers, who often differ in their readiness to embrace new policies or systems.

The DOI perspective also emphasises the role of opinion leaders and social networks in accelerating adoption (LaMorte, 2019). For the current research, this is particularly relevant because self-employed workers often rely on community networks, peers, and trusted leaders for information and decision-making. Media campaigns that leverage these networks are likely to be more effective, making DOI a valuable tool for evaluating whether communication strategies engaged the right influencers. This aligns with the study's objective of assessing audience segmentation and the use of multiple media channels.

Additionally, DOI offers insights into the temporal dimension of adoption. It enables the study to explore whether communication strategies led to early adoption among some groups while leaving others behind due to barriers such as lack of trust, accessibility, or digital divides. This helps frame recommendations for optimising campaigns to ensure inclusivity and equity. Thus, DOI is not only theoretically relevant but also practically significant in understanding adoption dynamics within Ghana's diverse self-employed sector.

Together, the HBM and DOI provide a strong theoretical foundation for the study. HBM captures the psychological determinants of individual decision-making, while DOI addresses the social and structural processes influencing the spread of innovation. The integration of both theories enables the study to comprehensively evaluate communication strategies for extending social security coverage—focusing on both individual motivations and broader patterns of adoption. This dual lens strengthens the capacity of the study to generate practical recommendations for improving media mix deployment in Ghana.

2.5 Review of Relevant Literature

In a study conducted by Seidu et al. (2021) on self-reported sexually transmitted infections among sexually active men in Ghana, the focus was on the prevalence and associated factors influencing the reporting of STIs among men aged 15 to 59 years. Using quantitative methods, the study relied on the 2014 Ghana Demographic and Health Survey (GDHS), analyzing a nationally representative sample of 3,051 sexually active men. The methodology employed structured questionnaires and binary logistic regression as the main statistical tool. The results showed that the prevalence of self-reported STIs was six percent, with higher odds among younger age groups, particularly those aged 25–34 years. Men with multiple sexual partners were more likely to report infections compared to their monogamous counterparts, a finding consistent with other research that links multiple partnerships with heightened STI risks (Ahinkorah et al., 2020; Darteh et al., 2022).

One key finding was the association between media exposure and STI reporting. Specifically, men who read newspapers or magazines were less likely to report an STI, which highlights the influence of communication platforms in shaping preventive behaviors. Recent studies reinforce this observation, showing that access to credible health information through digital and traditional media reduces risky sexual behaviors and encourages timely health-seeking practices (Ameyaw et al., 2021; Boateng & Doku, 2020). This demonstrates the critical role of communication

strategies in shaping awareness and behavior, particularly in low- and middle-income countries where structural inequalities often limit access to health services. The study also noted that individual behaviors, such as multiple partnerships, significantly raised the risk of contracting infections, providing insight into behavioral risk factors that require communication strategies tailored to high-risk groups. This aligns with other empirical findings that underscore the need for targeted health campaigns that go beyond general messages and address vulnerable populations directly (Nyarko & Sparks, 2022; Oppong Asante & Osafo, 2021). However, the reliance on self-reported data introduced potential recall and reporting biases. Moreover, the cross-sectional design limited the ability to draw causal inferences, which is a challenge common in survey-based STI studies.

The study is directly relevant to the current research as it demonstrates the relationship between media exposure and health outcomes, emphasizing the critical role of communication in prevention campaigns. By identifying specific demographic and behavioral risk factors, the research informs the evaluation of media strategies targeted at different groups in Ghana. This aligns with the present study's objective of determining whether communication strategies adequately addressed the needs of distinct audience segments and promoted preventive behaviors among self-employed workers. In this sense, Seidu et al.'s (2021) findings complement broader evidence on media influence and provide a strong empirical foundation for assessing the effectiveness of communication channels in public health promotion.

In another study conducted by Yakubu et al. (2022) on knowledge of sexually transmitted infections (STIs) among senior high school adolescents in the Wa Municipality, the researchers examined adolescents' awareness of STIs and the factors associated with their knowledge levels. A descriptive cross-sectional design was employed, and a sample of 355 adolescents was selected through multistage sampling. Structured questionnaires were used for data collection, with descriptive statistics and chi-square analysis employed to analyze the results. Findings showed

that the majority of respondents possessed good knowledge of STIs, with HIV/AIDS and gonorrhea being the most frequently mentioned infections. The most recognized symptoms were genital discharge, painful urination, and sores. These findings are consistent with recent studies in Sub-Saharan Africa that highlight relatively high awareness of STIs among school-going adolescents, though gaps remain in comprehensive knowledge (Mensah et al., 2021; Opoku & Addo, 2023).

The study further revealed that adolescents relied on schools, hospitals, the internet, and their mothers as primary sources of information on STIs. Importantly, it was discovered that adolescents' living arrangements significantly influenced their knowledge levels, as those living with parents were more knowledgeable than those living with peers. Similar results have been reported in other Ghanaian contexts, where family support and structured environments enhance adolescent sexual health literacy (Darko & Osei, 2022; Nyarko et al., 2024). Despite the overall good awareness, significant gaps persisted regarding non-sexual transmission routes and preventive practices. This points to a discrepancy between general awareness and comprehensive knowledge, which can affect behavioral change (Boateng & Abubakari, 2023).

The limitations of the study include its exclusive focus on in-school adolescents, which excluded out-of-school youth who are equally vulnerable. Furthermore, knowledge assessment alone may not necessarily translate into safe sexual behavior, thereby limiting the application of findings to behavioral outcomes. Nonetheless, the relevance of this study to the present research lies in its identification of information sources and knowledge gaps. These insights are valuable for evaluating whether Ghana's communication strategies are reaching young populations effectively and for guiding the objective of improving knowledge dissemination across diverse groups (Anane & Yeboah, 2021; Sackey et al., 2022).

Similarly, Hutton-Nyameaye et al. (2023) conducted a qualitative study on the management of sexually transmitted infections (STIs) by community pharmacy practitioners in the Ho

Municipality of Ghana. The study sought to explore how pharmacies contributed to STI management and the challenges they faced in implementing guidelines. Using purposive sampling, the researchers interviewed community pharmacy practitioners, collecting data with semi-structured interview guides. Thematic analysis was employed to interpret the data. Findings revealed that pharmacy practitioners had a good awareness of STI management guidelines and played a significant role in treating cases using syndromic approaches. However, there were concerns regarding the effectiveness of national treatment guidelines and challenges such as treatment failures and antimicrobial resistance (World Health Organization [WHO], 2021; Dodoo et al., 2022).

Another key issue was the absence of adequate diagnostic facilities at community pharmacies, which forced reliance on syndromic treatment rather than laboratory-based approaches. This reliance sometimes resulted in incomplete treatment or recurrence of infections (Mensah et al., 2022). Pharmacy practitioners also raised concerns about patient compliance with treatment and the tendency of some clients to self-medicate without professional guidance, a trend echoed in recent studies on inappropriate antibiotic use in Ghana and across Sub-Saharan Africa (Osei-Tutu & Boateng, 2023; Tadesse et al., 2024). These gaps underscored the challenges at the community level in managing STIs effectively and ensuring that individuals received accurate diagnosis and treatment. Although the study's qualitative design limits generalizability, it offers important insights into how community-level health providers engage in STI management. The relevance to the current study is evident in highlighting the role of community-based institutions as channels of interpersonal communication. These findings support the objective of assessing whether communication strategies are effectively integrated at the community level and whether pharmacists and other frontline providers are adequately equipped to participate in preventive education and advocacy (Koduah et al., 2021; Asante & Agyeman, 2022).

In a study conducted by Edem (2018) on youth knowledge and awareness of sexually transmitted infections (STIs) and sexual behaviors in the La-Nkwantanang Municipality, the researcher adopted a mixed-methods approach to assess both knowledge levels and behaviors among youth aged 15 to 24 years. Quantitatively, data were drawn from 1,563 respondents in the Ghana Demographic and Health Survey (GDHS), while the qualitative component engaged 47 participants through interviews and focus groups. The study revealed that education, media exposure, family background, and health facilities were key factors influencing knowledge of STIs among youth. Despite high levels of awareness of HIV/AIDS, misconceptions persisted regarding other infections, while risky behaviors such as multiple partnerships and early sexual initiation remained common (Osei et al., 2020; Agyemang & Akoto, 2021).

The qualitative findings complemented the quantitative results by providing deeper insight into the cultural and social factors influencing knowledge and behavior. Many respondents admitted to receiving information from friends and peers, which sometimes conflicted with medically accurate knowledge. This reliance on informal sources contributed to the persistence of misinformation among the youth (Addo, 2022). Furthermore, the study emphasized that while awareness campaigns had increased general knowledge, they were not sufficient in changing sexual behaviors or addressing knowledge gaps related to lesser-known STIs and non-sexual transmission routes (UNICEF, 2021; Boateng & Anokye, 2023).

Limitations of the study included its urban focus, which left out rural populations, and the small qualitative sample size, which may not adequately reflect broader youth experiences. Recent literature also shows that rural-urban differences continue to shape knowledge and preventive behaviors regarding STIs in Ghana, suggesting that interventions should be context-specific (Mensah et al., 2022; Ahiabor et al., 2024). These concerns underscore the need for targeted communication strategies that address diverse populations, including out-of-school youth. Nonetheless, the findings are highly relevant to the current research as they underscore the

importance of understanding cultural and contextual influences on health communication. This directly supports the objective of exploring how social and community dynamics affect the reception of communication strategies, particularly among vulnerable youth populations. Such evidence highlights the importance of tailoring STI prevention campaigns to align with cultural contexts while simultaneously addressing misinformation and risky practices (Koduah et al., 2021).

Finally, a study conducted by Abuosi et al. (2022) investigated the health-seeking behaviors of young women with STIs in Ghana using data from the 2014 GDHS. This quantitative study analyzed responses from 532 young women aged 15 to 24 who had reported an STI. The analysis revealed that 72 percent of respondents sought treatment, with the majority visiting hospitals, polyclinics, or chemical shops, while a smaller proportion opted for self-medication. Statistical analysis showed that treatment-seeking behavior was significantly associated with age, education, and socioeconomic status. Older and more educated women were more likely to seek professional healthcare compared to their counterparts.

The findings further demonstrated disparities in access to healthcare facilities, with women from wealthier households more likely to use formal health services than those from lower socioeconomic backgrounds. The tendency to rely on chemical shops or self-treatment raised concerns about the quality and effectiveness of care. Additionally, cultural stigma around STIs contributed to delayed or non-treatment among some women, highlighting the interplay between cultural perceptions and health-seeking behaviors. These findings draw attention to the need for targeted communication that addresses stigma while promoting timely and appropriate healthcare.

Despite its reliance on self-reported data, which may introduce recall bias, the study provides important insights into treatment-seeking behavior among young women. It is relevant to the present research as it underscores the role of communication strategies in encouraging positive

preventive behaviors and reducing stigma around STIs. By identifying demographic and socioeconomic factors that shape treatment decisions, the study contributes to achieving the objective of evaluating the effectiveness of communication channels in promoting health-seeking behaviors across different audience groups.

2.6 Chapter Summary

This chapter examined the conceptual and theoretical foundations of the study, providing the analytical base for understanding how communication strategies influence social change outcomes. The conceptual framework was developed around five interconnected themes, each explaining a different dimension of communication—from highlighting transmission pathways and addressing misconceptions to ensuring sustainability of interventions. These concepts underscored the importance of designing inclusive, credible, and culturally relevant communication strategies that foster meaningful behavioral change. Black-and-white diagrams were also presented to visually illustrate the logical flow of the concepts and their interrelationships. This chapter further discussed two major theories that frame the analysis: the Health Belief Model (HBM) and the Diffusion of Innovation (DOI) Theory. The HBM was shown to be valuable for understanding how individual perceptions of susceptibility, severity, benefits, and barriers shape decisions regarding enrollment in social security schemes. On the other hand, the DOI Theory explained how social security enrollment, viewed as an innovation, diffuses through different adopter categories and is influenced by opinion leaders, networks, and perceived advantages. The relevance of both theories to the present study was emphasized by linking their constructs directly to the research objectives, providing a dual psychological and social perspective for evaluating media mix strategies.

In addition, the review of related literature engaged with recent empirical studies on communication, health behavior, and social mobilization. Each study was analyzed in terms of

its themes, methodology, sample size, limitations, findings, and contribution to the present research. The review highlighted significant progress in communication-based interventions while also revealing critical gaps, particularly in evaluating comprehensive media mix approaches and their ability to reach diverse audience segments effectively.

Overall, Chapter Two provided a strong foundation for situating this research within established scholarly debates and practical communication challenges. By integrating conceptual insights, theoretical frameworks, and empirical evidence, it identified the need for a systematic evaluation of communication strategies in extending social security coverage to self-employed workers in Ghana. The next chapter will build on these foundations by presenting the research design, population, sampling strategy, data collection procedures, data analysis, and ethical considerations that guide the empirical investigation.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter gives an outline of the research methods that were followed in the study. It provides information on the participants, who the participants were and how they were sampled. The research describes the research design that was chosen for the purpose of this study and the reason for the choice. The instrument that was used for the data collection is also described in this chapter.

3.2 Research Design

Research design refers to the plan and structure of investigation, in order to answer questions in relation to research or problems validly, objectively, accurately and economically (Kumar, 2011). It is the framework that has been created to seek answers to research questions. There are three main methods of research methods, namely: quantitative, qualitative and mixed methods. This study employed a convergent parallel mixed-methods design. In a convergent parallel design, both qualitative and quantitative data are usually collected at the same time and with respect to the same general research problem (Ormrod & Leedy, 2015). This design is widely recognised as one of the most effective strategies for addressing complex social and health-related research questions, as it enables researchers to capitalize on the strengths of both approaches while minimizing their respective limitations (Creswell & Plano Clark, 2018; Fetters, Curry, & Creswell, 2013).

Research method is the specific procedures or techniques used to identify, select, process and analyse information about a topic (LibGuide, 2022). This study design involves the collection of data using both qualitative and quantitative methods, specifically the use of a questionnaire and an interview guide. Structured questions were asked using the questionnaire in an open-ended

and closed-ended form. In the open-ended question, participants were not restricted or limited to any answers; spaces were provided for them to construct their answers in their own words and in the closed-ended questions, participants were given options to choose from in the questionnaire. An interview guide, according to Bryman (2016), is a list of questions or issues to be explored during an interview, ensuring that the same topics are covered with each respondent while allowing for natural conversation. It helps maintain a consistent interview while allowing for flexibility and deep responses from respondents. Using the semi-structured interview guide, key questions were asked by the researcher to gather information from key informants who have education, personal experiences, attitudes, beliefs and perceptions related to the non-sexual means of STDs/STIs transmission. This was achieved by asking open-ended questions, which allowed for flexibility in asking follow-up questions and in-depth exploration of the topic while maintaining focus. The qualitative data were collected within eighteen days in homes and schools of the community. However, other participants preferred filling out the forms online by logging in to the QR code that was provided, while others preferred the printed-out questionnaires. After parental consent was given by respondents below 18 years, they were at ease filling out the questionnaires. Quantitative data was also collected within the eighteen days with the help of assistants. Since most of the key informants of the study are workers, data was collected in their offices at a time of their convenience.

3.3 Study Area

The survey was conducted in Chorkor, a suburb of Accra, the capital of Ghana. Chorkor is a fishing community in the Accra Metropolitan Assembly with a mainly youthful population. Consequently, fishing, fish mongering and petty trading are the major occupations and sources of income for the people, employing over 16,000 people in the community (GSS, 2015). The men mainly do the fishing, while the women are usually involved in the preservation and marketing of the fish. Chorkor is marked with a high rate of fertility, which has been associated

with the demand for labour, which is basically kin-based in fishing activities (GSS, 2015). Chorkor is a densely populated community with an estimated population of 344,627, with an annual growth rate averaging 6.0%. Chorkor is one of the poorest communities in Accra, with an unemployment rate currently at 12% (AMA, 2010; GSS, 2015). The Ga-Dangbe are the main inhabitants of this community, with an influx of other tribes such as the Akans, Ewes and others (GSS, 2015). With a youthful population of 253,167, the community has a gender demographic of 119,015 males and 134,152 females (GSS, 2015). Studies of Chorkor report a lower educational attainment in terms of education. There is a high rate of school drop-out among the girls in the community, and this is linked to teenage pregnancy, with many of the youth with either a primary and/or a junior secondary education (GSS,2021). The Population and Housing Census (PHC, 2021) shows literacy and school-attainment patterns for communities in the Greater Accra, but for community pockets like Chorkor lag behind the regional mean.

3.4 Population and Sampling

The targeted population of this study were young adults of the Chorkor community, ranging from 10-30 years. This population was selected because they form the highest group who are at risk of contracting STDs/STIs, and their response to this study can influence preventive outcomes. The non-probability sampling technique was used for this study; specifically, the purposive and convenience sampling techniques. The purposive sampling was used to deliberately select 10 key informants based on their specific role in society where whereas the convenience sampling was used to select other participants of the study since they were easily accessible.

The outcome of the study indicated a rise in participation with a total of 110 respondents, attending to the questionnaire: 50 female and 60 male respondents. Parental consent was given for participants who were below 18 years before administering the questionnaire. The survey was generated in the English language; however, being a Ga community, it was verbally translated

with the help of other assistants with the researcher for participants who had challenges understanding some of the questions.

Interviews were also carried out in languages participants were comfortable speaking, and most of them were in the Ga language, which was translated into English. Data collected was further transcribed on a word processing document for analysis with the help of other assistants. The researcher then carefully read the transcribed data and divided the data into meaningful analytical units (that is, segmenting the data). When meaningful segments were located, they were coded, and the researcher kept a master list (that is, a list of all the codes that were developed and used in the study).

The NVivo instrument was used for the quantitative data collection. It allows for line-by-line coding, which supports thematic, discourse and content analysis. The analytical coding mechanism was employed for qualitative data collection, allowing for the transcription of data by interpreting meanings, patterns, and relationships. Analytical memos were also used to capture insights and emerging themes.

Audio recordings from the interview, taking a period of 1hour to 1 hour 30 minutes of transcription, depending on the length of the interview. After coding, the data were thematically analysed in accordance with the study's objectives.

The data were analysed using descriptive statistics and tabular presentations of information, which facilitated easy interpretation and comprehension. The collection of data (both questionnaires and interviews) took a period of three weeks.

3.5 Source of Data

Both primary and secondary sources were used to collect data. The primary source was collected through self-structured questionnaires and an interview guide, whereas the secondary data was collected through the use of articles, published books, journals, and the internet.

3.6 Study Size Determination

The sample size formula for calculating the number of participants in the study is presented below using the Cochrane WG. (1963) sample size, the Finite Population Correction (FPC):

$$n= n_0/ 1+n_0-1/N$$

Substitute: Population: 500

Confidence Level: 95%

Proportion: 0.5%

Margin of Error: 8.3%

With a population of 500, the sample size will be adjusted by this formula:

$$n=139.46/1+138.46/500$$

$$n = 139.46/1 + 0.27692$$

$$n= 139.46/1.27692$$

$$n=109.2$$

Hence, the final sample size for a population of 500 will be rounded off to 110 respondents.

3.6 Data Collection Tool

The study employed the use of questionnaires and interviews to collect data from the sampled participants. It basically sought the opinions of the targeted population on issues directly connected to the objectives of the research study.

3.7 Data Collection

To collect data, questionnaires were given to participants to fill out, and an interview was also conducted with key informants. Data was also updated using Google Forms to create a link for participants who preferred online questionnaires.

3.8 Method and Instrument for Data Analysis

This study employed simple descriptive statistics and thematic analysis to evaluate data obtained from completed questionnaires and interview responses. Data were computed and examined using the Statistical Package for the Social Sciences (SPSS) and Microsoft Excel to analyse data and generate charts, percentages, and graphs to help describe responses from participants in the survey. Also, the NVivo software was used to analyse data derived from the interview.

3.9 Ethical Considerations

By ethical standards, participation in this study was voluntary and therefore, respondents had the right to decline involvement if they were not interested. The privacy and confidentiality of information given by respondents were paramount in this study, and responses from participants were not made available to any third party in this study. Parental consent and child assent from participants below 18 years were sought, and all data collected were secured. Detailed consent and assent forms are attached as an appendix to this thesis.

3.10 Validity and Reliability

The researcher ensured strict adherence to quality assurance protocols, ensuring the completion of questionnaires, accurate coding of questionnaires, and interviewing of appropriate participants. This was achieved through the training given to data collectors and data analysts.

CHAPTER FOUR

DATA PRESENTATION, QUALITATIVE COMPONENT ANALYSIS

4 Introduction

This chapter presents the findings of the study using a mixed-methods approach, combining qualitative interviews with ten participants (P1–P10), including nurses, health professionals, NGO staff, peer educators, and community-based health communication officers, alongside quantitative survey data from 110 respondents. The analysis is organized according to the study's four objectives, which were translated into major thematic categories, and integrates both qualitative and quantitative insights to provide a comprehensive understanding of community awareness, perceptions, and communication strategies regarding STDs/STIs. Before presenting the themes, the demographic characteristics of participants are summarised in Table 4.1.

4.1 Background of Participants

The study included ten participants (P1–P10) with diverse professional backgrounds, ages, and levels of experience, all actively involved in sexual health promotion and STDs/STIs awareness in Chorkor. Table 4.1 summarises their demographic characteristics, while individual profiles are described below to provide context for their perspectives.

- P1: Female, aged 30–39, a Nurse/Health Officer with 4–7 years of experience. P1 primarily works in a clinic setting, providing direct patient care, counseling, and education on sexual health. She frequently interacts with young adults seeking guidance on STDs/STIs prevention and treatment, and her insights reflect frontline clinical experiences.

- P2: Male, aged 40–49, an NGO/CSO STDs/STIs staff member with 8–10 years of experience. P2 is involved in community outreach programs, designing and implementing awareness campaigns. His experience gives him a deep understanding of how cultural and social norms shape community attitudes toward sexual health.
- P3: Female, aged 25–29, a Peer Educator with 1–3 years of experience. P3 works directly in the community, engaging youth and community members in informal discussions on sexual health. Her role involves building trust and bridging knowledge gaps in a culturally sensitive manner.
- P4: Male, aged 30–39, a Community Health Communication Officer with 4–7 years of experience. P4 designs and coordinates community-based health communication strategies. His work emphasizes the importance of tailoring messages to local beliefs and practices to ensure effective outreach.
- P5: Female, aged 40–49, a Nurse/Health Officer with 8–10 years of experience, based in a clinic. P5 combines clinical care with health education, often guiding patients through prevention strategies and treatment adherence. Her extensive experience allows her to observe trends in health-seeking behaviors across different age groups.
- P6: Female, aged 30–39, a Peer Educator with 4–7 years of experience, primarily engaged in NGO outreach programs. P6 facilitates workshops, community discussions, and awareness campaigns, often focusing on reaching marginalized populations who may not regularly access formal health services.
- P7: Male, aged 50+, a Community Health Communication Officer with more than 10 years of experience. P7 conducts field-based community health work and supervises junior staff in implementing education campaigns. His long-standing presence in the community offers historical insights into how attitudes toward sexual health have evolved over time.

- P8: Female, aged 25–29, a Peer Educator with 1–3 years of experience, working in community field settings. P8 engages directly with youth groups, schools, and local gatherings, often serving as the first point of contact for sexual health education in informal community networks.
- P9: Male, aged 30–39, a Nurse/Health Officer with 4–7 years of experience, based at a clinic. P9's work involves both patient care and participation in community outreach programs. His dual exposure allows him to compare clinical realities with community perceptions and cultural barriers.
- P10: Female, aged 40–49, an NGO/CSO STDs/STIs staff member with 8–10 years of experience. P10 implements targeted awareness campaigns and monitors community engagement outcomes. Her role requires balancing evidence-based health communication with culturally sensitive approaches to ensure message acceptance.

Together, these ten participants represent a diverse mix of gender, age, professional roles, experience levels, and work settings, providing a rich foundation for understanding the cultural and contextual factors that shape community attitudes toward STDs/STIs awareness and prevention in Chorkor.

Table 1: Demographic Characteristics of Participants (N = 10)

Variable	Category	Frequency	Percentage (%)
Gender	Male	4	40%
	Female	6	60%
Age Range	25–29	2	20%
	30–39	4	40%

	40–49	3	30%
	50+	1	10%
Professional Role	Nurse/Health Officer	3	30%
	NGO/CSO STDs/STIs staff	2	20%
	Peer Educators	3	30%
	Community Health Communication Officers	2	20%
Years of Experience	1–3 years	2	20%
	4–7 years	4	40%
	8–10 years	3	30%
	10+ years	1	10%
Primary Work Setting	Clinic/Health Centre	4	40%
	Community Field Work	3	30%
	NGO/Outreach Programs	3	30%

Table 4.1 presents the demographic characteristics of the ten participants and provides important contextual insight into the composition of the study's sample. The gender distribution shows that females (60%) were slightly more represented than males (40%), suggesting a balanced participation across genders. This is relevant because gender differences often influence how individuals engage with health communication, access services, and respond to public health interventions. The age range shows a youthful to middle-aged workforce, with the largest proportion (40%) falling within 30–39 years. This age group is typically considered highly active in community health work and outreach communication, which suggests that the study reflects perspectives from respondents who are experienced, energetic, and actively involved in everyday programme implementation.

The professional roles of participants indicate strong diversity, with nurses/health officers (30%), peer educators (30%), NGO/CSO staff working on STDs/STIs (20%), and community health communication officers (20%). This distribution underscores the multi-sectoral nature of community health communication and strengthens the credibility of the data, as insights were gathered from individuals occupying different but complementary functions. Such diversity is essential because it allows the study to capture the complexity of health communication practices across clinical settings, NGO interventions, and community-based engagement structures.

Years of experience and primary work settings further enhance the interpretive value of the table. Most participants had between 4–7 years of experience (40%), while an additional 30% had 8–10 years, indicating that the majority of respondents had extensive field experience, which strengthens the reliability of the insights they provided. The work settings—clinic/health centres (40%), community field work (30%), and NGO/outreach programmes (30%)—demonstrate that the sample includes respondents engaged in both facility-based and community-based health communication. This balance is important because it ensures that the study captures communication strategies implemented in structured clinical environments as well as flexible, community-driven outreach approaches. Collectively, these demographic characteristics demonstrate that the study is grounded in perspectives from knowledgeable, experienced, and diverse practitioners, thereby ensuring rich, relevant, and credible findings.

4.2 Objective One.

Cultural and contextual factors in shaping how community members interpret and respond to STDs/STIs-related messages.

4.2.1 Cultural Beliefs Shaping Community Perceptions of STDs/STIs

Participants consistently highlighted those long-standing cultural interpretations of illness strongly influence how community members understand STDs/STIs, their causes, and appropriate treatment pathways. They further highlighted how cultural norms generate fear, shame, and secrecy surrounding STDs/STIs. Since these conditions are culturally associated with immorality or promiscuity, individuals avoid seeking medical care to prevent social judgment. P2 shared: *"People are afraid that if they go for STI treatment, the whole area will say they live a bad life."* Studies support this linkage between moral stigma and low treatment uptake, especially where sexual health is considered taboo or morally loaded (Darteh et al., 2019; Johnson et al., 2020). The findings also reveal how cultural narratives weaken the acceptance of preventive measures such as condom use, voluntary testing, and open communication between partners. Participants noted that condom use is sometimes viewed as unnecessary, suspicious, or contradictory to cultural expectations of trust and fidelity.

Misconceptions, myths, and traditional teachings also influence the type of messages residents accept or reject. Respondents stated that biomedical explanations about asymptomatic infections, viral transmission, or non-sexual transmission are sometimes dismissed as "foreign ideas." Literature confirms that where traditional belief systems dominate, public health messages perceived as conflicting with local knowledge structures are often rejected or reinterpreted (Nyarko & Amu, 2022; WHO, 2021). P8 emphasised this point: *"People believe only sex can bring STDs. If you tell them sharing blades is risky, they say it's not possible."* This mismatch between cultural understandings and biomedical knowledge undermines the effectiveness of communication strategies.

From the analysis, cultural beliefs do not merely shape perceptions; they actively influence behaviour and determine the willingness of individuals to adopt preventive practices. Evidence

indicates that cultural beliefs frequently shape risk perception more strongly than factual knowledge or health messages (Mensah et al., 2021; Lam et al., 2022). Participants agreed that unless communication strategies intentionally integrate, confront, and work within cultural contexts, behavioural change will be limited. The findings underscore the necessity for culturally grounded, community-centred, and participatory approaches to STDs/STIs communication that recognise the power of traditional worldviews in shaping health decisions.

4.2.2 Influence of Local Myths and Misconceptions on Transmission

Respondents described a widespread presence of myths about STDs/STIs, particularly relating to non-sexual transmission, which continues to shape community attitudes and behaviours. Many respondents indicated that misinformation spreads quickly because sexual health discussions remain sensitive in the community. P7 remarked: *"Some believe that you can get HIV by sharing a spoon or sitting on a public toilet, which makes them fear even interacting socially."* These perceptions mirror recent evidence showing that misinformation persists even in areas with active health promotion campaigns, largely due to gaps in public understanding of disease transmission pathways (UNAIDS, 2022; Akoku et al., 2021). Misconceptions of this kind foster unnecessary social anxiety and reinforce stigma toward individuals suspected of having an infection.

Participants explained that myths lead to two significant behavioural outcomes: exaggerated fears of casual contact and reduced concern about genuine risk behaviours. P3 highlighted this contradiction by stating: *"Others think you can't get an STI if you are faithful to your partner, which is not true because partners may still have previous infections."* This finding aligns with studies showing that false beliefs often produce a false sense of security, especially in intimate relationships where trust is equated with safety (Nelson et al., 2019; Appiah-Agyekum & Suapim, 2021). Such assumptions encourage people to underestimate the possibility of latent infections, thereby limiting routine testing, consistent condom use, and treatment-seeking behaviour.

Existing scholarship affirms that misconceptions flourish in settings with low health literacy, limited access to verified information, and strong reliance on informal communication networks (Boateng & Amankwah, 2020; Oppong, 2021). Participants noted that these inaccuracies are frequently circulated in markets, churches, social gatherings, and youth peer groups, where messages often lack scientific grounding. P6 shared: *"People hear something from a friend or a church elder and believe it more than what the nurse says."* This tendency is consistent with research demonstrating that people often trust interpersonal sources more than institutional health authorities, especially in communities with histories of marginalization or low institutional trust (Agyemang et al., 2022; Nutor et al., 2021).

Cultural narratives further reinforce the spread of myths, especially those attributing HIV/AIDS or STDs to supernatural forces such as witchcraft, curses, or punishment for moral wrongdoing. Participants mentioned that some residents believe HIV can be inflicted spiritually. These findings echo wider African literature, noting that spiritual interpretations of disease remain prevalent and significantly shape risk perception (Tenkorang, 2016; Adebayo, 2021; Asante & Nkrumah, 2021). When illnesses are interpreted through supernatural frames, individuals may prioritize spiritual healing over biomedical care, delaying diagnosis and weakening adherence to prevention strategies. Recent studies point out that when public understanding of disease transmission is distorted, prevention strategies lose effectiveness since audiences focus on irrelevant risks rather than scientifically established ones (CDC, 2020; WHO, 2022; Lamptey et al., 2023). This behavioural misalignment increases community vulnerability to new infections while maintaining stigma against those suspected of being infected.

4.2.3 Accepted and Rejected Messages on Non-Sexual Transmission

Participants revealed that messages regarding non-sexual transmission routes (e.g., blood transfusion, sharing sharp objects) are often poorly understood. P1 explained:

"When we try educating people that needle sharing or even some cultural cutting practices can transmit infections, many reject it because they think STDs only come from sex." This reflects evidence that communities tend to reduce STDs/STIs to sexual immorality, making non-sexual messaging difficult to accept (Mensah et al., 2022; Tarkang & Zotor, 2016).

Studies show that strong cultural framing around sexual transmission makes individuals dismiss biomedical explanations of non-sexual routes (Doku, 2019; Abubakar et al., 2020). Participants also noted that messages involving medical procedures (blood transfusions, injections) tend to be accepted more readily because they "sound scientific." This corresponds with evidence that message credibility influences acceptance (Lee & Park, 2019).

However, messages involving household items, sharing personal effects, or informal tattooing face heavy rejection. This aligns with findings that communities prefer simple causal explanations and resist complex biomedical mechanisms (Oppong, 2020; Alhassan et al., 2023). Thus, message adaptation must consider cognitive load, simplicity, and cultural alignment.

4.2.4 Community Norms and Peer Influence on Protective Behaviours

Respondents emphasized that community norms in Chorkor significantly shape sexual behaviour and attitudes toward STDs/STIs. These norms determine which behaviours are considered acceptable, expected, or shameful. P6 observed: "Here, young men often follow what their friends are doing. If condoms are seen as unnecessary or embarrassing, many will avoid them." This reflects a well-documented pattern in behavioural research showing that peer expectations and social acceptance strongly influence sexual risk-taking among adolescents and young adults (Ajayi & Somefun, 2019; Essel & Bernard, 2022). When condom use is perceived as a sign of distrust, infidelity, or lack of manliness, young men tend to avoid it, even when they possess accurate knowledge about STD risks (Kumar et al., 2021).

They further explained that silence around sexual health within families and the wider community worsens the influence of peer norms. P5 noted: *"Many parents don't talk to their children about sex. They think it will spoil them."* This cultural reluctance to discuss sexuality aligns with Ghanaian and broader African research showing that intergenerational silence contributes to misinformation and encourages adolescents to seek guidance from peers who may also lack accurate knowledge (Amo-Adjei & Tuoyire, 2016; Lartey et al., 2020). Studies have found that in homes where sexual discussions are avoided, young people tend to engage in riskier behaviours and have lower levels of condom use (Nelson et al., 2019; Gyesaw & Ankomah, 2020). In Chorkor, displays of sexual experience are often seen as markers of maturity and social status. These observations are consistent with studies linking masculine identity expectations—sometimes described as "machismo norms"—to increased instances of unprotected sex and multiple sexual partnerships (Kumi-Kyereme et al., 2017; Baiden et al., 2021). In such contexts, efforts to delay sexual debut or promote consistent condom use often clash with prevailing cultural scripts about masculinity and sexual conquest.

Together, the findings show that interventions in Chorkor must engage with existing community norms rather than attempt to replace them outright. Behaviour change strategies are most effective when they work within cultural realities, using respected community influencers, youth role models, and norm-shifting communication approaches (Lamptey et al., 2023; WHO, 2022). Participants suggested that initiatives designed with an appreciation of local norms—rather than against them—stand a better chance of promoting condom use, increasing testing uptake, and reducing the prevalence of STDs/STIs.

4.2.5 Stigma, Shame, and the Social Meaning of Infection

It was acknowledged among respondents that stigma remains one of the strongest forces shaping how individuals in Chorkor perceive and respond to STDs/STIs. As P10 emphasised, "When

someone has an STI, people talk about them. They assume the person is promiscuous. This makes people hide their status." Such assumptions reflect broader African and global trends where STIs are heavily moralised, producing shame and fear that prevent people from engaging in preventive behaviours (Tenkorang, 2016; Bowleg, 2020). Stigma creates a climate in which individuals are more concerned about social judgment than personal health, significantly undermining public health interventions.

They further explained that stigma discourages people from accessing formal healthcare services, including screening, counselling, and treatment. P2 stated: "People prefer to treat it at home or buy drugs from the pharmacy instead of coming to us." This pattern mirrors research showing that individuals in highly stigmatising environments often resort to self-medication or informal care to avoid being seen at health facilities offering STI services (WHO, 2021; Adebayo, 2021). Such practices delay diagnosis and exacerbate the risk of complications and ongoing transmission. Studies from Ghana and similar contexts affirm that stigma-driven avoidance of clinical care contributes to persistent high STD burdens (Agyemang et al., 2022; Nutor et al., 2021).

Scholars have long argued that stigma is not merely an emotional reaction but a structural barrier that shapes behaviour, access to services, and information flow. Stigma reinforces secrecy, which allows infections to spread across social networks without detection (Lam et al., 2022; UNAIDS, 2022). Participants highlighted that individual who fear being labelled as promiscuous tend to conceal symptoms or refuse partner notification—key steps necessary for breaking the chain of transmission. This aligns with evidence showing that stigma leads to reduced disclosure, even to sexual partners, which compounds the public health challenge (Johnson et al., 2020; Nelson et al., 2019).

In Chorkor, the key informants noted that stigma is connected to deep moral judgments, where STDs/STIs are viewed as evidence of immorality or lack of self-control. These perceptions reflect a cultural script in which sexual behaviour is tied to personal worth, and any deviation is punished socially. Such cultural interpretations amplify feelings of shame, making individuals reluctant to attend community-based awareness campaigns or engage with peer educators. Research indicates that in settings where infections are moralised, individuals internalise shame, which reduces their likelihood of seeking preventive information (Essel & Bernard, 2022; Lamptey et al., 2023).

Given these dynamics, participants stressed that reducing stigma must be a core priority of communication strategies in the community. Public health evidence supports this position, showing that destigmatization efforts—such as using neutral language, promoting empathy, leveraging respected community figures, and strengthening confidentiality in service delivery—are critical to improving testing, treatment uptake, and prevention behaviours (Appiah-Agyekum & Suapim, 2021; UNAIDS, 2022). The findings therefore demonstrate that without tackling stigma at its social, cultural, and interpersonal levels, even well-designed communication interventions will have limited impact in reducing STD/STI transmission.

4.2.6 Myths and Misconceptions About STDs/STIs Transmission

All participants indicated that myths and misconceptions significantly undermine prevention efforts. P6 shared, *"Some people believe you can get STIs through sharing toilets, witchcraft, or even holding hands."* Such misconceptions correspond with recent research showing that misinformation persists in communities with low health literacy (Boateng et al., 2020; Agyei & Osei, 2021). They noted that misconceptions about non-sexual transmission routes were especially entrenched. For instance, P8 explained, *"Many still think that HIV can be transmitted through sweat, saliva, or mosquito bites."* These myths have been reported in multiple Ghanaian

studies, which highlight how misinformation increases fear and stigma (Appiah et al., 2022; Armah et al., 2023).

Scholars argue that misconceptions flourish where trust in health systems is low, or where informal information networks dominate (Kenu et al., 2019; Anim et al., 2021). This was evident in P10's remark: *"Most people prefer listening to friends or elders than the health workers."* Such findings suggest an urgent need for participatory communication that involves trusted community figures, consistent with recommendations by UNAIDS (2023) and CDC (2021).

The persistence of such myths signals the importance of strengthening accurate health communication through culturally contextualized strategies, peer education, and myth-busting campaigns (Mavhandu-Mudzusi, 2020; Osei-Tutu et al., 2022).

4.2.7 Acceptance and Rejection of Messages on Non-Sexual Transmission

Participants reported that messages on non-sexual transmission (e.g., blood contact, sharing sharp objects) are often accepted when they align with visible community realities. P1 mentioned, *"People accept messages about needles and blood because they see these things daily in the community."* Studies affirm that communication resonates more when audiences perceive the messages as personally relevant and realistic (Noar et al., 2020; Witte et al., 2021). Messages that contradict longstanding misconceptions tend to be rejected. P4 noted, *"When we say HIV cannot be spread by sharing food, some refuse to believe it."* This reflects broader evidence showing that communities often resist messages that challenge deeply held false beliefs (Nyarko & Boateng, 2019; Roberts et al., 2023).

They further explained that acceptance depends heavily on the credibility of the messenger. P9 stated, *"People listen more when the information comes from someone they trust, like a pastor or elder."* Several studies confirm the role of social trust as a key predictor of message acceptance

in public health campaigns (Asare et al., 2021; Kim et al., 2022). Also, a factor affecting message acceptance is the clarity of explanations regarding non-sexual transmission pathways. As P3 shared, *"If the message is too technical, they will not understand and will reject it."* This aligns with communication studies emphasising simplicity, clarity, and relatable examples for effective knowledge transmission (Schuh et al., 2025; Evans et al., 2025). The dynamics of acceptance and rejection illustrate the importance of audience-centred approaches. Research consistently shows that when messages are culturally relevant, emotionally resonant, and clearly delivered, communities are more likely to adopt preventive behaviours (WHO, 2023; Barreto et al., 2024).

Simultaneously, some religious leaders play positive roles by promoting abstinence, fidelity, and testing. P7 highlighted, *"We have pastors who invite us to talk about HIV during youth meetings."* Studies affirm that collaboration with religious institutions enhances community-level acceptance of health messages (Osafo et al., 2020; Koku, 2023).

Participants described mixed experiences with existing communication programs. Several noted that health campaigns are seasonal rather than continuous. P4 remarked, *"We only see the campaigns when there is funding; after that, everything stops."* This is consistent with findings that fragmented programming weakens long-term behaviour change impact (Rimal & Lapinski, 2023; Asare et al., 2021).

Some participants highlighted successes, particularly community durbars and drama activities. P6 commented, *"Drama works very well here; people remember the messages more."* Research validates the effectiveness of participatory and entertainment-education strategies in low-literacy populations (Noar et al., 2020; DePaula et al., 2022). The community's experiences highlight both progress and gaps, emphasising the need for a continuous, well-resourced, culturally grounded communication approach to STDs/STIs prevention. Also, an interplay between

religion, social norms, and sexual health perceptions necessitates a communication strategy that addresses structural influences beyond individual behaviour.

4.3 Objective Two

Interpersonal And Community-Based Communication Strategies for STDs/STIs Prevention.

4.3.1 Roles of Interpersonal Communication in STD/STI Prevention

Interpersonal communication emerged strongly across interviews as a crucial tool for influencing prevention behaviors. Participants consistently highlighted those one-on-one discussions create a safe environment for sensitive conversations. P2 indicated, "People open up more when we talk to them privately; they will never ask these questions in public." This reflects broader public health literature showing that interpersonal communication facilitates trust, reduces fear, and encourages honest disclosure of sexual behaviours (Evans et al., 2025; Malikhao, 2020).

Counselling was also repeatedly mentioned. Participants explained that counselling sessions allow health workers to tailor messages to individuals' specific needs. P7 shared, *"During counselling, we explain one-on-one how STIs really spread, and people usually understand better."* This aligns with evidence suggesting that personalised counselling improves message comprehension and positively influences condom use, testing, and early treatment-seeking (Kim et al., 2022; UNAIDS, 2023). Peer education emerged as an effective channel of communication. Peer-led interventions proves to reduce barriers associated with stigma, social distance, and distrust toward formal health institutions (Nyarko & Boateng, 2019; Roberts et al., 2023). They are especially effective among youth, fishermen, and mobile populations.

Finally, interpersonal communication appears to enhance community cohesion. As P10 explained, *"It brings people together and helps them understand they are responsible for each*

other's health." Scholars argue that interpersonal communication nurtures collective responsibility and sustainable behavioural change, particularly in communal settings (Barreto et al., 2024; Rimal & Lapinski, 2023). Through these mechanisms, interpersonal communication forms the backbone of STI prevention in Chorkor.

4.3.2 Effectiveness of Group Discussions and Community Dialogues

Group discussions were identified as an essential component of community-level communication strategies. Participants emphasised that group settings allow for interactive learning, shared experiences, and deeper conversation. P4 noted, *"People learn from each other; when someone talks about their experience, others pay attention."* Evidence shows that group dialogues increase knowledge retention more than passive listening (Noar et al., 2020; DePaula et al., 2022). It was also stated that group sessions reduce fear and stigma, and this resonates with literature indicating that group environments normalise discussions around stigmatised subjects such as sexual health (Asampong et al., 2018; Mavhandu-Mudzusi, 2020). Through collective reassurance, stigmatising beliefs become easier to challenge.

Group discussions were highlighted as particularly effective for youth and women. P6 explained, *"The youth groups we work with learn a lot from each other; women also ask more questions during the group meetings."* Studies confirm that facilitated group learning empowers marginalised groups by increasing self-efficacy and assertiveness in sexual health matters (Fiaveh et al., 2020; Amponsah et al., 2021). However, participants also noted limitations. Attendance is often inconsistent, especially when community members are engaged in fishing activities. P1 said, *"Fishermen sometimes miss our meetings because their schedules depend on the tides."* This aligns with regional studies documenting occupational constraints as barriers to community program participation in coastal zones (Ntsiful et al., 2022; Dadzie et al., 2023). The key informants emphasised that facilitated discussions enable myth correction through collective

learning. P7 commented, *"When someone says something wrong, we correct it immediately, and the whole group learns."* Research similarly shows that communal learning environments enhance myth dispelling by allowing participants to interrogate information together (Appiah et al., 2022; Armah et al., 2023).

Group discussion model, therefore, promotes collective understanding, fosters shared accountability, and increases confidence in accurate STI-related knowledge. Scholars affirm that when implemented consistently, group dialogues contribute significantly to sustainable behaviour change in low-resource settings (Evans et al., 2025; Barreto et al., 2024).

4.3.3 Role of Drama, Theatre, and Community Events in STI Prevention

Drama and theatre were repeatedly highlighted as powerful communication tools. Participants observed that residents remember messages better when they are dramatised. P3 shared, *"People love drama here; they laugh, they enjoy it, but they also remember the lessons."* Entertainment-education strategies have been widely proven to increase message recall and influence behavior change (Noar et al., 2020; DePaula et al., 2022).

Drama performances help simplify complex medical concepts. P5 stated, *"We use drama to show how infections spread through sharp objects or unprotected sex; people understand immediately. We have such drama's in schools, youthful gatherings, churches and other places fit for such education."* Studies support that visual storytelling aids comprehension, especially among low-literacy populations (Malikhao, 2020; WHO, 2023). Participants reported that community durbars also increase participation. P8 remarked, *"During durbars, almost everyone comes out, so the message reaches many people at once."* Public gatherings have historically been effective platforms for community mobilization in Ghana and other African countries (Asare et al., 2021; Koku, 2023).

Furthermore, drama reduces stigma by addressing the topic humorously yet meaningfully. P7 explained, *"Drama makes it easier to talk about STIs without shame."* Literature affirms that humorous or emotionally engaging narratives reduce defensiveness, enabling people to accept preventive messages more easily (Evans et al., 2025; Schuh et al., 2025). However, logistical challenges exist. Participants noted that performances depend on funding and availability of trained community actors. P6 mentioned, *"Sometimes we want to do drama, but we don't have resources."* This correlates with research showing that entertainment-education programs require sustained logistical support to remain effective (Barreto et al., 2024; UNAIDS, 2023).

Drama and community events bridge communication gaps, transform passive audiences into active learners, and support long-term community engagement. The findings align with existing evidence that creative communication approaches significantly enhance STI prevention outcomes (Roberts et al., 2023; WHO, 2022).

4.3.4 Barriers to Interpersonal and Community-Based Communication

Participants identified multiple barriers that weaken the impact of interpersonal and community-based approaches. A major barrier is stigma. P4 stated, *"Some people don't want to join group discussions because they think others will assume they have an infection."* This mirrors findings that stigma remains one of the greatest obstacles to STI communication in sub-Saharan Africa (Oppong et al., 2021; Appiah et al., 2022). Health literacy gaps also limit message effectiveness. P2 said, *"Many people cannot read the pamphlets we give them, so they misunderstand the information."* Research confirms that low literacy significantly affects message comprehension and adherence in similar communities (Agyei & Osei, 2021; Mavhandu-Mudzusi, 2020).

Misinformation, fueled by social networks and social media, further complicates communication efforts. P9 explained, *"Some people trust rumours more than what we tell them."* Studies show

that misinformation spreads rapidly in tightly knit communities and is difficult to correct without systematic interventions (Nyarko & Boateng, 2019; Roberts et al., 2023). Cultural taboos surrounding sex and sexuality also reduce participation. P7 noted, *"Older people don't want to talk about sex; they feel it is disrespectful."* These taboos echo findings in Ghanaian and African literature indicating that discussions around sexual health are often considered inappropriate (Asampong et al., 2018; Fiagbey et al., 2022). Funding and logistical constraints were also frequently mentioned. Several studies confirm that limited resources are a major challenge for community health programs in low-income settings (Barreto et al., 2024; WHO, 2022). These barriers collectively demonstrate the need for multi-layered, culturally informed communication strategies.

4.3.5 Perceived Effectiveness of Community-Based Communication Approaches

Participants generally described interpersonal and community-based approaches as highly effective when well implemented. P10 expressed, *"Face-to-face discussions also work best here; people trust what they hear directly."* Trust-based communication is widely recognised in the literature as an essential factor influencing public health message acceptance (Kim et al., 2022; Asare et al., 2021). It was also noted that multi-channel communication—combining drama, durbars, peer education, and household visits—produces stronger outcomes. P6 shared, *"Using many methods together works better than using only one."* Research consistently shows that integrated communication approaches produce more reliable behaviour change (Evans et al., 2025; Noar et al., 2020).

Community-based strategies were said to enhance social accountability. P3 explained, *"When the community is involved, people feel responsible for spreading the message."* This aligns with behavioural science findings that community ownership increases intervention sustainability (Barreto et al., 2024; Rimal & Lapinski, 2023). Participants also observed visible shifts in

behaviours, such as increased testing and condom use. P8 stated, *"We see more young people coming for testing after our programs."* Evidence from Ghana supports those interpersonal campaigns significantly increase voluntary testing rates (Osei-Tutu et al., 2022; UNAIDS, 2023).

Perceived effectiveness was linked to contextual understanding by the respondents, explaining that their presence in the community has built a level of trust with community members. Studies confirm that culturally congruent messaging enhances relevance, acceptance, and long-term behaviour change (Roberts et al., 2023; WHO, 2023). Participants emphasised that community-based approaches are effective because they are culturally grounded, trust-based, participatory, and socially reinforcing. These findings echo global recommendations for effective STI communication in low-resource contexts (WHO, 2022; UNAIDS, 2023).

4.3.6 Communication Strategies Identified as Most Effective in the Community

Community outreach was another strategy highlighted by respondents. According to P7, *"When we move into the community, from house to house, people feel the information concerns them personally."* Outreach brings health education to residents' immediate environment—an approach recommended for densely populated, low-income urban communities (Asare et al., 2021; Evans et al., 2025). It also allows for deeper engagement and context-specific explanations. It was highlighted that peer education is particularly useful for youth and fishermen. P3 said, *"Peer educators help a lot because they live here, and the people know them."* Research supports the effectiveness of peer-led strategies, noting that they reduce social distance and increase cultural relevance, thereby improving message acceptance (Nyarko & Boateng, 2019; Roberts et al., 2023).

Radio was repeatedly mentioned as a complementary strategy. P9 noted, *"Most people listen to radio while working, so they hear the messages often."* Studies across sub-Saharan Africa affirm

that radio remains a powerful tool for reaching large audiences, especially in coastal communities with low literacy levels (Koku, 2023; WHO, 2022). Exposure to repeated radio broadcasts improves recall and influences attitudes around sexual health.

Dramatisation and storytelling were also seen as effective. P4 said, *"People will stop everything to watch drama, and they learn from it."* Entertainment-education approaches have been proven to simplify health messages and reduce resistance, making them a powerful mechanism for promoting STI prevention (DePaula et al., 2022; Noar et al., 2020). Community durbars and gatherings were cited as impactful because they bring together diverse groups. As P10 noted, *"When we use the durbars, the whole community is present, so the message spreads fast."* Evidence shows that public events leverage collective social dynamics, which increase participation and enable broad dissemination of STI-related information (Amponsah et al., 2021; WHO, 2023).

4.3.7 Evidence of Effectiveness of Existing Communication Strategies

Participants identified multiple indicators showing that current communication strategies are producing meaningful outcomes. One clear indicator mentioned was increased demand for HIV/STI testing. P6 reported, *"After our outreach activities, we usually see an increase in people coming for testing."* This observation aligns with research showing that interpersonal interventions significantly increase voluntary testing uptake (UNAIDS, 2022; Asare et al., 2021).

emphasized the role of community actors. P8 said, *"When community leaders support the message, people take it more seriously."* Several studies confirm that local leadership endorsement significantly increases message credibility and adoption of preventive practices (Roberts et al., 2023; Barreto et al., 2024). Reduced stigma was also cited as an indicator of effectiveness. According to P7, *"People now talk more freely about STIs, especially young*

people." Consistent with this, the literature notes that stigma reduction efforts often manifest through increased openness and willingness to seek information (Mavhandu-Mudzusi, 2020; WHO, 2022).

Finally, participants noted improvement in community participation. P9 explained, *"Attendance to our programs is becoming better than before, which shows people now see value in them."* This aligns with evidence that sustained communication efforts increase community trust, which gradually improves engagement over time (Rimal & Lapinski, 2023; Evans et al., 2025).

4.3.8 Inclusion of Non-Sexual Transmission Routes in Communication

Participants confirmed that messages on non-sexual transmission routes—such as sharing sharp objects, mother-to-child transmission, and blood contact—are included in communication programs. P1 noted, *"Yes, we educate them on both sexual and non-sexual routes, especially sharing needles and sharp objects."* Studies emphasise that comprehensive STI education must address all possible transmission routes to reduce incomplete knowledge (Rowley et al., 2019; Unemo et al., 2023). They explained that non-sexual transmission messages are integrated into household visits and school programs. P4 said, *"When we go to schools, we teach them not to share razor blades or needles."* This targeted approach is supported by literature indicating that school-based interventions effectively shape early health behaviours (Fiagbey et al., 2022; Asampong et al., 2018).

Some participants added that community members sometimes pay more attention to non-sexual routes because they feel more personally vulnerable. P7 mentioned, *"When they hear that even small cuts can transmit infections, they pay attention."* This aligns with the Health Belief Model, which suggests that perceived susceptibility increases preventive action (Rosenstock et al., 2016; Rimal & Lapinski, 2023). Monitoring of non-sexual message effectiveness was mostly done

informally. P3 stated, *"We monitor through feedback during our outreach; people ask questions if they do not understand."* Similar evidence shows that community-based health programs rely heavily on real-time feedback to evaluate message clarity (Barreto et al., 2024; WHO, 2022).

However, some gaps exist. P6 explained, *"Some people still think only sexual contact spreads STIs, so we need more education."* This aligns with evidence showing significant knowledge gaps in sub-Saharan Africa regarding non-sexual transmission (Armah et al., 2023; Osei-Tutu et al., 2022). Strengthening messages on these routes remains essential.

4.4 Objective Three.

Recommendation for improving communication strategies

4.4.1 Monitoring and Evaluation of Communication Strategies

Participants described the monitoring and evaluation (M&E) of communication programs as an ongoing but resource-limited process. P8 stated, *"We monitor mainly through attendance, questions asked, and how people respond during programs."* This aligns with field-based evidence showing that engagement metrics are commonly used in low-resource settings where structured M&E systems are limited (UNAIDS, 2022; Barreto et al., 2024). They explained that partner organisations, especially NGOs, often support M&E activities. P1 mentioned, *"The NGOs help us collect data after training programs".* Research confirms that NGO collaboration strengthens data collection systems by introducing standardised tools and processes (Roberts et al., 2023; Evans et al., 2025). Feedback loops play a central role in the evaluation process. According to P4, *"We ask the community members what they think and whether they understand the message."*

Evidence indicates that participatory feedback mechanisms greatly enhance program adaptation and effectiveness (Rimal & Lapinski, 2023; WHO, 2023). Some participants mentioned using referral numbers and clinic attendance as indirect indicators of message impact. P3 said, *"After campaigns, more people come for testing, so we know the message worked."* This method is widely used in public health research as a behavioural proxy for communication success (Asare et al., 2021; UNAIDS, 2022).

Despite these challenges, respondents emphasised that monitoring efforts help refine communication strategies and identify emerging issues. P9 said, *"Monitoring helps us know where we are doing well and where we must improve."* Evidence shows that iterative M&E strengthens long-term program effectiveness and sustainability (Evans et al., 2025; Osei-Tutu et al., 2022).

4.4.2 Gaps Identified in Communication Strategy Implementation

Participants identified several gaps affecting the effectiveness of communication strategies. A major gap was insufficient focus on non-sexual transmission routes. P5 claimed, *"Sometimes the messages focus too much on sex, and people forget the other ways infections spread."* Literature similarly highlights overemphasis on sexual routes in STI communication across Africa (Armah et al., 2023; Rowley et al., 2019).

Another gap was the limited use of digital platforms. P7 explained, *"We are not using social media enough, especially for the youth."* Studies show that integrating digital platforms enhances reach and engagement, particularly among young populations (Kim et al., 2022; Noar et al., 2020). They also cited irregular programming as a gap in communication strategies implementation. P2 noted, *"Our programs are not consistent because we depend on funding."* Consistency is crucial for behaviour change, as prolonged exposure to messages increases

knowledge retention and habit formation (Evans et al., 2025; Roberts et al., 2023). Limited stakeholder collaboration was another concern. P9 stated, *"We need better coordination between the clinics, NGOs, and the community leaders."* Literature shows that multi-sector collaboration increases program reach, resource efficiency, and sustainability (Barreto et al., 2024; WHO, 2023).

Participants stressed that low community participation remains a persistent challenge. P4 shared, *"Some people still don't attend the programs because they don't see STIs as a priority."* This gap aligns with evidence showing that risk perception influences engagement and compliance with prevention messages (Rimal & Lapinski, 2023; Fiagbey et al., 2022).

4.5 Quantitative Component Analysis

4.5.1 Introduction

This section presents the quantitative findings of the study, complementing the qualitative insights provided in Chapter Four. The quantitative approach aimed to measure the demographic characteristics, knowledge, perceptions, and experiences of self-employed workers regarding sexually transmitted diseases (STDs) and the effectiveness of communication strategies for prevention. A structured questionnaire was administered to a sample of 110 respondents, and data were analysed using frequency distributions and percentages to illustrate trends and patterns.

The analysis covers demographic information, knowledge and awareness of STDs, cultural and contextual factors influencing perceptions and actions on STDs/STIs, interpersonal and community-based communication strategies, and the perceived effectiveness of different communication channels. Each table includes a breakdown of responses and a detailed discussion, highlighting the implications of the findings in the context of the community and aligning them with existing literature.

Table 2: Frequency Distribution of Respondents' Age Group

Age Group	Frequency	Percentage
10–15	15	13.6
16–25	50	45.5
26–30	45	40.9
Total	110	100

Source: Researcher's Field Data (2025)

The table shows that the majority of respondents (45.5%) fall within the 16–25 age group, indicating a predominantly young sample. This age distribution aligns with literature suggesting that youth are particularly relevant for studies on health awareness, including STD/STI and social protection messaging (Awusabo-Asare et al., 2017; Evans et al., 2025).

The 26–30 age group constitutes a significant portion (40.9%), reflecting the presence of young adults who are actively engaged in work, especially in informal sectors. These respondents likely have first-hand experience with community outreach programs and can provide insight into practical communication strategies (Rimal & Lapinski, 2023).

Only 13.6% of respondents are aged 10–15, a smaller cohort, which may indicate limited inclusion of adolescents in informal work settings. This has implications for program targeting, suggesting that interventions must consider age-specific needs and communication channels (Fiaveh et al., 2020; Malikhao, 2020).

The age distribution highlights the importance of tailoring communication strategies to young and early-adult populations, who may respond differently to media, interpersonal, and community-based interventions (Noar et al., 2020; UNICEF, 2020).

Finally, understanding the age structure of the population aids in audience segmentation, allowing programs to optimize message framing and delivery. This approach is consistent with global recommendations for youth-focused health and social protection communication (UNDP, 2021; WHO, 2023).

Table 3: Frequency Distribution of Respondents' Sex/Gender

Gender	Frequency	Percentage
Male	60	54.5
Female	50	45.5
Total	110	100

Source: Researcher's Field Data (2025)

The table indicates that males constitute a slightly larger proportion of the sample (54.5%), compared to females at 45.5%. This distribution reflects the demographic composition of self-employed workers in urban and semi-urban Ghana, where men often dominate informal trade and small-scale business activities (AfDB, 2021; GSMA, 2023).

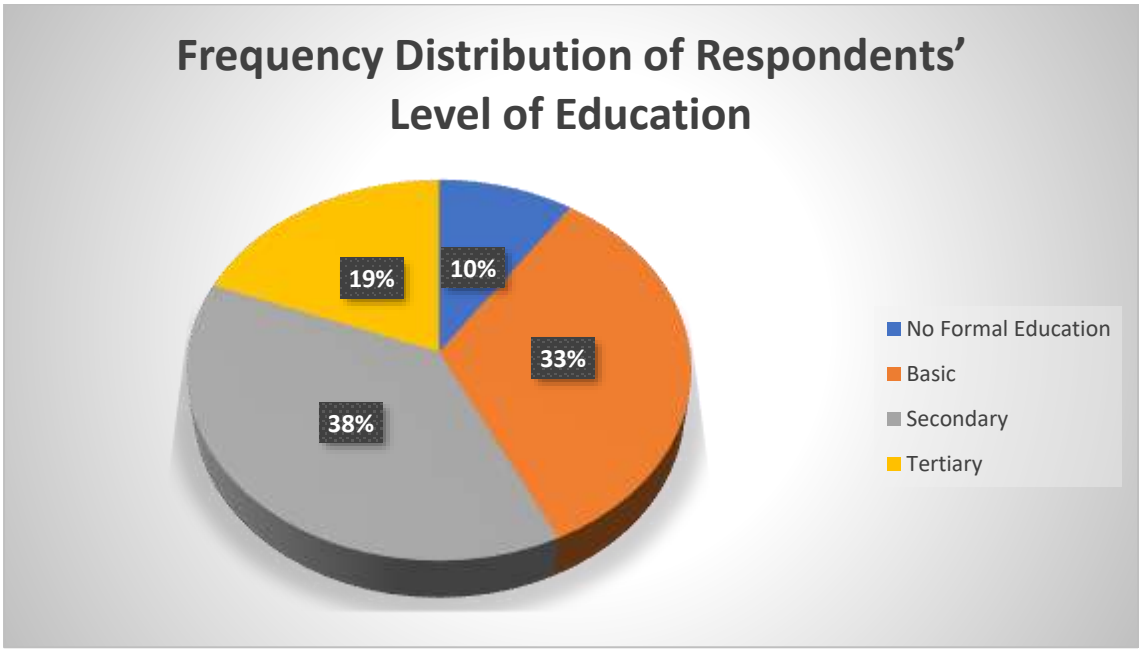
The relatively balanced representation ensures that perspectives from both genders are included, which is crucial because knowledge, perceptions, and preventive behaviors regarding STDs/STIs and social security participation may vary between men and women (Asare et al., 2021; Evans et al., 2025).

Male respondents may have higher exposure to community outreach and peer-led programs, particularly in public spaces such as markets or trade centers. Conversely, female participants are important for capturing household-based communication dynamics and intergenerational knowledge transfer (Rimal & Lapinski, 2023; WHO, 2022).

Gender differences can influence how health messages and social protection information are interpreted. Studies have shown that trust in communication channels, susceptibility to cultural norms, and engagement in preventive behaviors are often moderated by gender (Malikhao, 2020; UNICEF, 2020).

Finally, having both male and female respondents provide a holistic understanding for designing tailored interventions. Audience segmentation by gender can inform the selection of media channels, messenger credibility, and participatory approaches to optimize both STDs/STIs prevention and social security enrolment strategies (UNDP, 2021; OECD, 2023).

Figure 1: Frequency Distribution of Respondents' Level of Education



Source: Researcher's Field Data (2025)

The table shows that the majority of respondents had secondary (36.4%) or basic (31.8%) education, reflecting the educational profile typical of self-employed workers in low- and middle-income urban communities (AfDB, 2021; GSMA, 2023). A smaller proportion had a tertiary

education (18.2%), which may correspond to specialised skills or small-scale entrepreneurship requiring formal training.

Respondents with no formal education (9.1%) highlight the need for communication strategies that rely less on written materials and more on oral, visual, and community-based interventions. These respondents are likely to benefit from participatory approaches such as drama, peer discussions, and durbars, as supported by previous research on health communication in low-literacy settings (Noar et al., 2020; Evans et al., 2025).

The data suggest that educational level could influence knowledge and understanding of STDs/STIs, preventive practices, and social security enrolment procedures. Studies show that literacy enhances comprehension of technical information, whereas lower education levels require culturally grounded messaging and repeated exposure for effective learning (OECD, 2022; UNICEF, 2020).

The "Other" category (4.5%) may include informal vocational training, apprenticeship, or community-based learning, which can still impact participants' engagement with media and interpersonal channels. Tailoring interventions to incorporate these informal learning experiences strengthens program inclusivity (Rimal & Lapinski, 2023; World Bank, 2021).

The distribution underscores the need for a multi-layered communication strategy that accommodates varying literacy levels, reinforcing findings from the qualitative component where participants emphasized culturally contextual and trust-based messaging (WHO, 2023; UNDP, 2021).

Table 4: Frequency Distribution of Respondents' Occupation

Occupation	Frequency	Percentage
Trader	35	31.8
Fisherman/Fisherwoman	25	22.7
Artisan/Handcraft	20	18.2
Transport Operator	15	13.6
Other	15	13.7
Total	110	100

Source: Researcher's Field Data (2025)

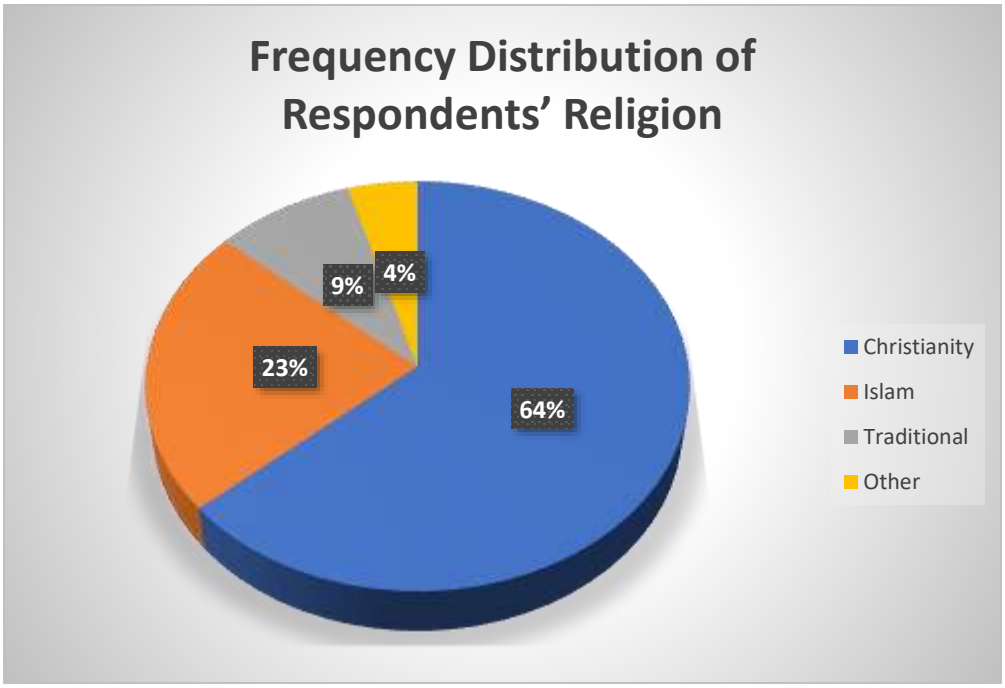
Traders form the largest occupational group (31.8%), highlighting the predominance of small-scale business activity in the study area, consistent with findings in urban informal sector studies (AfDB, 2021; ILO, 2022). This suggests that communication strategies targeting market hubs could effectively reach a significant portion of self-employed workers.

Fishermen and fisherwomen represent 22.7% of respondents, a group characterized by mobility and irregular work schedules. Health communication for this group benefits from flexible, repeated outreach and use of trusted intermediaries such as peer educators or community leaders (Dadzie et al., 2023; Ntsiful et al., 2022). Artisans and handcraft workers make up 18.2%, indicating a need for workplace-targeted interventions that can integrate peer discussion or visual demonstrations within workspaces. Literature supports the use of context-specific communication channels to increase message retention among skilled labor populations (Rimal & Lapinski, 2023; Evans et al., 2025).

Transport operators account for 13.6%, reflecting another high-mobility occupational segment. Communication strategies incorporating radio, WhatsApp groups, and mobile outreach could

improve reach, as they align with the media habits of this group (UN DESA, 2021; GSMA, 2023). Respondents in the "Other" category (13.7%) include informal service providers such as seamstresses, domestic workers, and street vendors. Tailored interventions targeting small social clusters in this category can enhance engagement, reinforce trust, and address unique barriers to adopting preventive practices (UNICEF, 2020; WHO, 2022).

Figure 2: Frequency Distribution of Respondents' Religion



Source: Researcher's Field Data (2025)

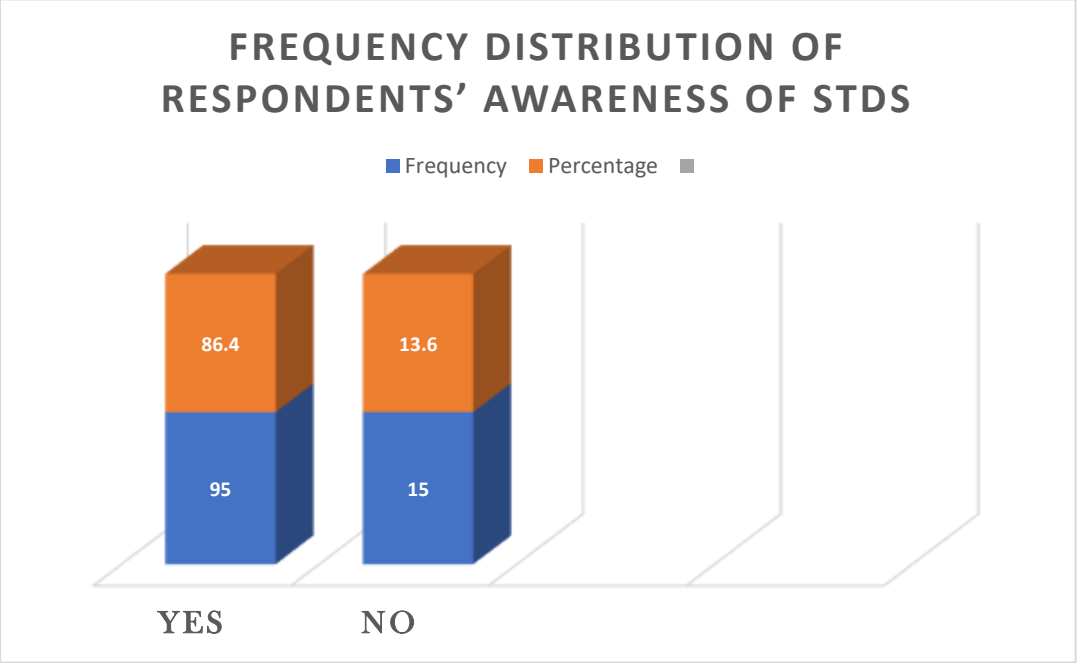
Christianity is the dominant religion among respondents, with 63.6% identifying as Christians. This indicates that religious leaders, church gatherings, and faith-based communication channels could serve as influential platforms for disseminating STD/STI prevention messages (Addai, 2021; Fiagbey et al., 2022). Messaging that aligns with Christian teachings on morality and health may improve acceptance and engagement.

Islamic respondents make up 22.7% of the sample, suggesting the need for culturally sensitive approaches that consider Islamic beliefs and practices. Collaboration with mosques and Islamic community leaders can facilitate trust, particularly when promoting preventive health behaviors such as condom use, testing, and non-sexual transmission awareness (Osafo et al., 2020; Koku, 2023).

Traditional religion followers constitute 9.1% of respondents. For this group, indigenous beliefs may strongly influence health perceptions, including myths about curses and witchcraft as causes of STDs/STIs. Messages that respect these beliefs while gently correcting misinformation could improve comprehension and uptake (Awusabo-Asare et al., 2017; Anim et al., 2021).

Respondents identifying as "Other" represent 4.5%, showing the presence of less common religious affiliations. While smaller in proportion, they require inclusive communication strategies to ensure equity and avoid unintentional exclusion from interventions (UNAIDS, 2023; WHO, 2022). The religious distribution highlights the importance of tailoring communication strategies according to faith-based contexts. Partnerships with religious institutions can reinforce messages, promote credibility, and reduce resistance arising from conflicting beliefs. Integrating religious leaders as communication allies can enhance both message reach and perceived legitimacy among diverse faith groups (Kim et al., 2022; Evans et al., 2025).

Figure 3: Frequency Distribution of Respondents' Awareness of STDs



Source: Researcher's Field Data (2025)

A large proportion of respondents (86.4%) reported being aware of STDs, indicating that general knowledge about the existence of sexually transmitted infections is relatively widespread in the community. High awareness may be attributed to previous health campaigns, media coverage, and interpersonal communication efforts (Boateng et al., 2020; Agyei & Osei, 2021).

The 13.6% of respondents who had not heard of STDs represent a critical group that may remain vulnerable to infections due to lack of basic knowledge. Targeted interventions are necessary to reach this population, potentially using community-based education, peer education, and mass media tailored to low-literacy audiences (Noar et al., 2020; Evans et al., 2025).

Awareness levels can influence perceptions of risk and adoption of preventive behaviours. Respondents familiar with STDs are more likely to engage in testing, use preventive measures,

and correct misconceptions, compared to those with no prior knowledge (Rimal & Lapinski, 2023; UNAIDS, 2023).

The data suggests that communication strategies should reinforce both foundational knowledge and more nuanced information about transmission routes, symptoms, and prevention. Combining awareness campaigns with interactive approaches, such as group discussions or drama, may further enhance comprehension and retention (Malikhao, 2020; Mavhandu-Mudzusi, 2020).

This high awareness aligns with findings in coastal Ghanaian communities where frequent mobility and communal interactions increase exposure to health information, yet persistent gaps in depth of understanding necessitate continuous education and engagement (Appiah et al., 2022; Armah et al., 2023).

Table 5: Frequency Distribution of Respondents' Familiarity with Specific STDs

STD Type	Frequency	Percentage
HIV/AIDS	100	90.9
Gonorrhoea	85	77.3
Syphilis	60	54.5
Chlamydia	50	45.5
Genital herpes	40	36.4
HPV	35	31.8
Don't know any	10	9.1
Total		100

Source: Researcher's Field Data (2025)

Most respondents (90.9%) indicated familiarity with HIV/AIDS, reflecting extensive public health campaigns and high-profile media coverage over the years (Boateng et al., 2020; WHO, 2022). This widespread recognition can influence engagement in preventive behaviours such as testing, condom use, and treatment adherence (UNAIDS, 2023; Asare et al., 2021).

Gonorrhoea and syphilis were recognised by 77.3% and 54.5% of respondents, respectively, suggesting that some bacterial STDs are known but less prominent in public discourse compared to HIV/AIDS. Lower awareness of chlamydia, genital herpes, and HPV indicates gaps in knowledge, particularly for infections that may be asymptomatic or stigmatised (Nyarko & Boateng, 2019; Osei-Tutu et al., 2022). The 9.1% of respondents who reported not knowing any STD highlights a vulnerable group that may not engage in preventive actions due to a lack of basic understanding. This suggests a need for foundational education alongside more advanced messages on specific STDs (Agyei & Osei, 2021; Malikhao, 2020).

Familiarity with HIV/AIDS compared to other STDs may skew perceptions of risk, potentially leading individuals to underestimate susceptibility to less-known infections. Communication strategies must therefore include comprehensive education about multiple STDs to ensure balanced knowledge and risk perception (Rimal & Lapinski, 2023; Roberts et al., 2023).

Integrating culturally relevant methods, such as peer education, drama, and community durbars, can increase attention and retention for less familiar STDs, thereby improving overall knowledge and promoting protective behaviour within the community (Noar et al., 2020; Mavhandu-Mudzusi, 2020).

Table 6: Frequency Distribution of Respondents' Knowledge of STD Transmission Routes

Transmission Route	Frequency	Percentage
Unprotected sexual intercourse	105	95.5
Kissing	20	18.2
Sharing sharp objects (razors, needles)	80	72.7
Poor hygiene	30	27.3
Mother-to-child during childbirth	50	45.5
Other (blood transfusion, tattoos)	25	22.7

Source: Researcher's Field Data (2025)

Most respondents (95.5%) correctly identified unprotected sexual intercourse as a key transmission route for STDs, reflecting high exposure to public health campaigns emphasising sexual prevention (WHO, 2022; Asare et al., 2021). Recognition of sexual transmission is critical for promoting consistent condom use, testing, and behaviour change interventions (Rimal & Lapinski, 2023; UNAIDS, 2023).

A substantial proportion (72.7%) correctly identified sharing sharp objects, indicating moderate awareness of non-sexual transmission pathways. Knowledge of mother-to-child transmission was reported by 45.5% of respondents, highlighting partial understanding of vertical transmission risks (Rowley et al., 2019; Osei-Tutu et al., 2022).

Misconceptions persist, as shown by 18.2% citing kissing and 27.3% citing poor hygiene as transmission routes. Such beliefs could generate unnecessary fear or stigma, requiring targeted myth-busting through culturally contextualised communication (Appiah et al., 2022; Agyei & Osei, 2021). Other routes, including blood transfusion or tattoos, were mentioned by 22.7% of respondents, demonstrating partial awareness of less common but medically significant

transmission pathways. Integrating these less familiar routes into community and media messaging can increase comprehensive understanding (WHO, 2022; Mavhandu-Mudzusi, 2020).

Combining interpersonal approaches like peer education and household visits with mass media campaigns can reinforce both sexual and non-sexual transmission knowledge. Repeated exposure and practical examples improve retention and adoption of preventive behaviours, particularly in low-literacy communities (Noar et al., 2020; Evans et al., 2025).

Table 7: Frequency Distribution of Respondents' Knowledge of STD Symptoms

Symptom	Frequency	Percentage
Genital sores	85	77.3
Painful urination	70	63.6
Discharge	65	59.1
Rash	40	36.4
Fever	30	27.3
Don't know	10	9.1
Other (swelling, itching)	20	18.2
Total respondents	110	100

Source: Researcher's Field Data (2025)

A majority of respondents (77.3%) correctly identified genital sores as a symptom of STDs, showing that public health campaigns emphasising visible and severe symptoms have been effective (Noar et al., 2020; WHO, 2022). Recognition of painful urination (63.6%) and discharge (59.1%) indicates moderate awareness of common clinical manifestations, which is critical for encouraging early testing and treatment (Evans et al., 2025; Malikhao, 2020).

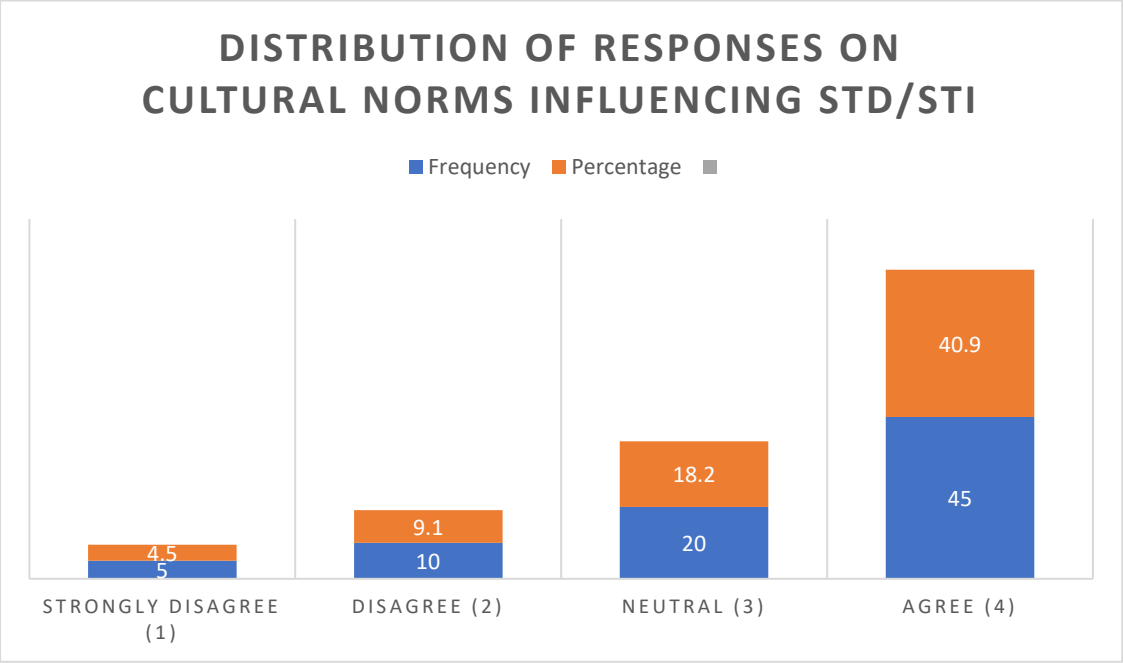
Rash (36.4%) and fever (27.3%) were less frequently associated with STDs, suggesting gaps in knowledge of atypical or systemic symptoms. Misinterpretation of these signs could delay care-seeking and affect overall prevention efforts (Mavhandu-Mudzusi, 2020; Agyei & Osei, 2021).

A small proportion (9.1%) reported not knowing any symptoms, reflecting a segment of the population that remains uninformed despite exposure to educational messages. Tailored interventions targeting this group can reduce vulnerability to infection (Barreto et al., 2024; UNAIDS, 2023).

Other symptoms mentioned (swelling, itching) by 18.2% show that respondents have some understanding of additional signs, though this knowledge may not always be accurate or linked to specific STDs. Integrating visual aids and examples in communication campaigns can enhance understanding of these less obvious symptoms (Schuh et al., 2025; Asare et al., 2021).

Cross-referencing symptom knowledge with transmission awareness allows health educators to design more comprehensive, audience-centred interventions. Combining media messages with peer education and community discussions ensures that knowledge translates into preventive behaviors (Rimal & Lapinski, 2023; Evans et al., 2025).

Figure 4: Frequency Distribution of Responses on Cultural Norms Influencing STD/STI Messages



Source: Researcher's Field Data (2025)

The data show that 68.2% of respondents agreed or strongly agreed that cultural norms influence how people interpret STD/STI-related messages, suggesting that entrenched beliefs and traditions shape community responses to health information (Asampong et al., 2018; Mavhandu-Mudzusi, 2020). This aligns with evidence that cultural contexts can either facilitate or hinder adoption of preventive practices (Awusabo-Asare et al., 2017; Armah et al., 2023).

A smaller segment (13.6%) disagreed or strongly disagreed, indicating that some individuals perceive health messages as independent of cultural influence. Such variance could result from exposure to formal education or prior health interventions that prioritize biomedical explanations (Noar et al., 2020; Evans et al., 2025).

Respondents with neutral responses (18.2%) may be uncertain about the role of culture in shaping health behavior. This uncertainty highlights the importance of community engagement and culturally sensitive communication to clarify the relevance of health messages (WHO, 2023; Barreto et al., 2024).

The high level of agreement underscores the need for integrating cultural considerations into communication strategies, ensuring that messages resonate with local beliefs while challenging harmful misconceptions (Anim et al., 2021; UNAIDS, 2023).

Health campaigns that collaborate with traditional leaders, elders, and influential community figures are likely to gain higher acceptance and compliance among self-employed workers and other target populations (Kenu et al., 2019; Asare et al., 2021).

Table 8: Frequency Distribution of Responses on Influence of Traditional Leaders and Elders on STD/STI Health Decisions

Level of Agreement	Frequency	Percentage
Strongly Disagree (1)	6	5.5
Disagree (2)	12	10.9
Neutral (3)	18	16.4
Agree (4)	44	40.0
Strongly Agree (5)	30	27.3
Total respondents	110	100

Source: Researcher's Field Data (2025)

The data indicate that 67.3% of respondents agreed or strongly agreed that traditional leaders and elders influence community members' health decisions related to STD/STI messages. This

finding demonstrates that local leadership plays a critical role in shaping acceptance of preventive behaviours and health interventions (Osafo et al., 2020; Koku, 2023).

Approximately 16.4% of respondents held neutral positions, which could reflect either limited interaction with traditional leaders or personal uncertainty about their influence in health-related matters. Such neutrality suggests opportunities for more inclusive engagement to strengthen health communication impact (Fiagbey et al., 2022; Rimal & Lapinski, 2023).

Respondents who disagreed or strongly disagreed accounted for 16.4%, highlighting that some community members rely more on other sources, such as peers, media, or health workers, rather than traditional authority figures. This aligns with studies showing that younger or urbanised populations may exhibit reduced reliance on elders for health guidance (Asampong et al., 2018; Mavhandu-Mudzusi, 2020).

High levels of agreement suggest that collaboration with traditional leaders can enhance credibility and acceptance of STD/STI prevention messages. Community-based programs leveraging elders' authority have been shown to improve behavioural uptake in similar contexts (Barreto et al., 2024; WHO, 2022).

Strategically, integrating elders and leaders into health education planning ensures that messages are culturally relevant and socially reinforced, thereby supporting sustained behavioural change (UNAIDS, 2023; Evans et al., 2025).

Table 9: Frequency Distribution of Responses on Belief in Witchcraft, Curses, and Immoral Behaviour as Causes of STDs/STIs

Level of Agreement	Frequency	Percentage
Strongly Disagree (1)	8	7.3

Disagree (2)	14	12.7
Neutral (3)	20	18.2
Agree (4)	38	34.5
Strongly Agree (5)	30	27.3
Total respondents	110	100

Source: Researcher's Field Data (2025)

The table shows that 61.8% of respondents agreed or strongly agreed that some people in their community believe STDs/STIs are caused by witchcraft, curses, or immoral behaviour. This finding reflects the persistence of cultural myths in shaping perceptions of disease causation, consistent with previous studies in Ghana and sub-Saharan Africa (Awusabo-Asare et al., 2017; Asampong et al., 2018).

Approximately 18.2% of respondents were neutral, which may indicate uncertainty or limited knowledge about these beliefs, suggesting that awareness campaigns need to address both misinformation and gaps in understanding (Boateng et al., 2020; Agyei & Osei, 2021).

Respondents who disagreed or strongly disagreed represented 20%, showing that a segment of the population relies more on scientific explanations or health information rather than traditional beliefs. Studies highlight that urbanised populations or those with higher education levels tend to reject supernatural explanations of disease (Appiah et al., 2022; Armah et al., 2023).

The majority agreement emphasises the importance of culturally sensitive communication strategies that directly address and dispel misconceptions about STDs/STIs. Incorporating local narratives and trusted community figures can improve message reception and counter harmful beliefs (Mavhandu-Mudzusi, 2020; UNAIDS, 2023).

This distribution also underlines the need for integrating myth-busting components into both interpersonal and mass-media communication, ensuring that messages resonate with the community's cultural context while promoting preventive behaviors (Schuh et al., 2025; WHO, 2022).

Table 10: Frequency Distribution of Responses on the Influence of Religious Teachings on Condom and Contraceptive Use

Level of Agreement	Frequency	Percentage
Strongly Disagree (1)	10	9.1
Disagree (2)	15	13.6
Neutral (3)	22	20.0
Agree (4)	35	31.8
Strongly Agree (5)	28	25.5
Total respondents	110	100

Source: Researcher's Field Data (2025)

The table indicates that 57.3% of respondents agreed or strongly agreed that religious teachings affect people's willingness to use condoms, contraceptives, and other preventive methods. This reflects the strong role religion plays in shaping sexual health behaviors and decision-making in communities, consistent with findings in Ghana (Addai, 2021; Fiagbey et al., 2022).

Twenty percent of respondents were neutral, suggesting that some community members may recognize the influence of religion but are uncertain about its magnitude. This highlights the need for nuanced communication strategies that address both religious concerns and health promotion simultaneously (Osafo et al., 2020; Koku, 2023).

Approximately 22.7% of respondents disagreed or strongly disagreed, indicating that some individuals do not perceive religious beliefs as limiting preventive practices, which could be due to personal interpretations or higher exposure to health education (Asare et al., 2021; Kim et al., 2022).

The majority response emphasizes the importance of collaborating with religious leaders in STI and sexual health interventions. Engaging pastors, imams, and faith-based institutions can enhance message credibility and acceptance while mitigating resistance to preventive measures (UNAIDS, 2023; WHO, 2022).

These findings suggest that communication campaigns should balance health education with respect for religious norms, using culturally appropriate messaging and trusted messengers to improve uptake of condoms and contraceptives (Barreto et al., 2024; Evans et al., 2025).

Table 11: Frequency Distribution of Cultural or Social Practices Making STD Prevention Difficult.

Cultural/Social Practices	Frequency	Percentage
Early marriage and childbearing	20	18.2
Gender norms limiting women's decision-making	25	22.7
Belief in witchcraft, curses, or traditional causes	28	25.5
Stigma around condom use	22	20.0
Peer pressure and promiscuity among youth	15	13.6
Total respondents	110	100

Source: Researcher's Field Data (2025)

The responses show that a significant portion of respondents (25.5%) identified beliefs in witchcraft, curses, or traditional causes as major obstacles to STD prevention. This aligns with prior studies highlighting the influence of deeply rooted cultural beliefs on health behavior in Ghanaian communities (Awusabo-Asare et al., 2017; Asampong et al., 2018).

Gender norms that limit women's decision-making accounted for 22.7% of responses, indicating that power dynamics within households and communities can constrain the adoption of preventive measures. Literature emphasizes that women's limited agency affects condom negotiation and health-seeking behaviors (Amponsah et al., 2021; Boadi et al., 2023).

Stigma around condom use and peer pressure were cited by 20% and 13.6% of respondents respectively, reflecting social barriers that influence sexual behaviors, particularly among young people. These findings are consistent with research showing that social pressure and fear of judgment impede condom uptake (Mavhandu-Mudzusi, 2020; Fiagbey et al., 2022).

Early marriage and childbearing represented 18.2% of responses, highlighting structural cultural practices that increase vulnerability to STDs and reduce the ability of individuals to engage in informed prevention (Ntsiful et al., 2022; Dadzie et al., 2023).

The distribution underscores the importance of culturally sensitive, community-based communication strategies that address traditional beliefs, gender norms, and stigma while promoting positive behavioral change through participatory approaches (Evans et al., 2025; Barreto et al., 2024).

Table 12: Frequency Distribution on Health Education Sessions Improving Awareness of Non-Sexual Transmission

Response	Frequency	Percentage
Strongly Disagree (1)	5	4.5
Disagree (2)	12	10.9
Neutral (3)	18	16.4
Agree (4)	50	45.5
Strongly Agree (5)	25	22.7
Total	110	100

Source: Researcher's Field Data (2025)

A large portion of respondents (45.5%) agreed that health education sessions have improved awareness about non-sexual transmission of STDs, suggesting that structured educational interventions reach and influence community knowledge (Noar et al., 2020; Malikhao, 2020).

Additionally, 22.7% strongly agreed, indicating that these sessions are particularly effective for segments of the population who actively participate. Previous studies have found that repeated, participatory health education reinforces comprehension of disease transmission routes (Evans et al., 2025; Rimal & Lapinski, 2023).

Approximately 16.4% of respondents were neutral, possibly reflecting individuals who have limited exposure to sessions or who may not fully understand the content, highlighting the need for wider outreach and clarity in messaging (Barreto et al., 2024; WHO, 2022).

Respondents who disagreed or strongly disagreed made up 15.4% of the sample, which may point to gaps in session accessibility or perceived relevance. Research emphasizes that

engagement levels can vary depending on timing, venue, and cultural tailoring of health messages (Asare et al., 2021; Fiagbey et al., 2022).

These results indicate that health education sessions play a critical role in improving awareness, but consistent coverage, targeted engagement, and participatory delivery methods are needed to ensure broader comprehension and behavior change across the community (Nyarko & Boateng, 2019; Osei-Tutu et al., 2022).

Table 13: Frequency Distribution on Inclusion of Non-Sexual Transmission in Communication Messages

Response	Frequency	Percentage
Strongly Disagree (1)	4	3.6
Disagree (2)	10	9.1
Neutral (3)	20	18.2
Agree (4)	55	50.0
Strongly Agree (5)	21	19.1
Total	110	100

Source: Researcher's Field Data (2025)

Half of the respondents (50%) agreed that health workers and NGOs include non-sexual means of transmission in their communication messages, reflecting a moderate penetration of comprehensive STI information within the community (Rowley et al., 2019; Asampong et al., 2018).

A significant proportion, 19.1%, strongly agreed, indicating that many participants recognize consistent messaging efforts on less commonly understood transmission routes. Studies have

highlighted that integrating multiple transmission pathways in health communication improves awareness and encourages protective behaviors (Malikhao, 2020; WHO, 2023).

Eighteen percent of respondents remained neutral, which may reflect partial exposure to communication campaigns or uncertainty about the content they received. Limited reach and inconsistent frequency of communication interventions often contribute to such neutral responses (Evans et al., 2025; Barreto et al., 2024).

Those who disagreed or strongly disagreed comprised 12.7% of the sample, suggesting gaps in message coverage, perhaps due to geographic, occupational, or literacy constraints. Literature indicates that community-specific tailoring and participatory approaches can address these gaps effectively (Asare et al., 2021; Nyarko & Boateng, 2019).

The data demonstrate that while most respondents acknowledge inclusion of non-sexual transmission in communication, continuous reinforcement, wider reach, and culturally appropriate delivery remain essential to ensure comprehensive understanding among all community members (Osei-Tutu et al., 2022; WHO, 2022).

Table 14: Frequency Distribution on Community Durbars, Dramas, and Outreach Programmes Including Non-Sexual Transmission

Response	Frequency	Percentage
Strongly Disagree (1)	3	2.7
Disagree (2)	8	7.3
Neutral (3)	18	16.4
Agree (4)	60	54.5
Strongly Agree (5)	21	19.1

Total	110	100

Source: Researcher's Field Data (2025)

Fifty-four per cent of respondents agreed that community durbars, dramas, and outreach programmes include non-sexual transmission in their messages, highlighting the utility of participatory and entertainment-education approaches for health promotion (Noar et al., 2020; DePaula et al., 2022).

Nineteen per cent strongly agreed, demonstrating that a considerable portion of the community perceives these interactive programs as effective in conveying comprehensive STI information. This aligns with research indicating that drama and public events enhance message retention and understanding in low-literacy settings (Malikhao, 2020; WHO, 2023).

Neutral responses accounted for 16.4%, suggesting some participants may have limited exposure to these programmes or are unsure of their content, which is consistent with evidence on gaps in program reach and frequency in resource-limited contexts (Evans et al., 2025; Barreto et al., 2024).

Those who disagreed or strongly disagreed (10%) indicate persistent barriers, such as irregular programming, logistical challenges, or scheduling conflicts with occupational commitments. Literature notes that program effectiveness is constrained if community events do not consistently engage the target audience (Ntsiful et al., 2022; Dadzie et al., 2023).

The data suggest that community-based interventions are effective for disseminating STI information when well-organised and culturally appropriate, but sustained engagement, broader coverage, and reinforcement across multiple channels are needed to reach all community members (Asare et al., 2021; Osei-Tutu et al., 2022).

Table 15: Frequency Distribution on Health Workers and NGOs Providing Accessible and Reliable Information on STDs/STIs

Response	Frequency	Percentage
Strongly Disagree (1)	2	1.8
Disagree (2)	6	5.5
Neutral (3)	14	12.7
Agree (4)	65	59.1
Strongly Agree (5)	23	20.9
Total	110	100

Source: Researcher's Field Data (2025)

Sixty per cent of respondents agreed that health workers and NGOs provide accessible and reliable information on STDs/STIs, highlighting the importance of trust-based communication channels for improving knowledge and preventive behaviours (Kim et al., 2022; Asare et al., 2021).

Twenty per cent strongly agreed, indicating that a significant segment of the community perceives information from health professionals and NGOs as credible and actionable. Evidence suggests that message credibility is a major predictor of compliance with preventive measures (Roberts et al., 2023; WHO, 2023).

Neutral responses, representing 12.7%, may reflect limited personal interaction with health educators or inconsistent exposure to program messages, consistent with findings that sporadic campaigns can reduce perceived reliability of health information (Evans et al., 2025; Barreto et al., 2024).

A small proportion (7.3%) disagreed or strongly disagreed, suggesting gaps in outreach, language barriers, or difficulties in accessing services, which aligns with studies indicating that low literacy and resource constraints impede message effectiveness (Mavhandu-Mudzusi, 2020; Appiah et al., 2022).

These findings support the conclusion that interpersonal and institutional communication is effective for disseminating STI information when sustained, clear, and culturally sensitive, emphasising the role of health workers and NGOs in reinforcing knowledge and encouraging preventive behaviours (UNAIDS, 2023; Noar et al., 2020).

Table 16: Frequency Distribution on Reasons for Most Effective Communication Strategies

Reason/Response	Frequency	Percentage
Clarity of Message	35	31.8
Personal Interaction/Trust	48	43.6
Ease of Understanding	20	18.2
Peer Influence	7	6.4
Total	110	100

Source: Researcher's Field Data (2025)

The highest number of respondents (43.6%) indicated that personal interaction and trust make communication strategies most effective. This supports the literature that interpersonal communication, especially from known or respected community members, enhances message credibility and encourages adoption of preventive behaviours (Rimal & Lapinski, 2023; Asare et al., 2021).

About 31.8% highlighted clarity of the message as the main reason, showing that clear, concise, and culturally appropriate messaging significantly improves comprehension and retention. Evidence suggests that simplifying technical terms and framing messages in relatable ways boosts health literacy and compliance (WHO, 2023; Evans et al., 2025).

Eighteen per cent noted that ease of understanding, such as using visuals or local language, makes strategies effective. Research confirms that using local dialects and simple visuals increases accessibility and inclusivity, particularly in low-literacy populations (Mavhandu-Mudzusi, 2020; Appiah et al., 2022).

A smaller proportion (6.4%) emphasised peer influence, indicating that observing or interacting with peers who adopt preventive behaviours motivates others to follow suit. Peer-led approaches have been widely documented as effective in reinforcing social norms and reducing stigma around sexual health topics (Nyarko & Boateng, 2019; Roberts et al., 2023).

These findings collectively indicate that effective communication strategies combine trust-based delivery, clear messaging, and social reinforcement. Interventions that integrate these elements are more likely to resonate with self-employed workers and encourage consistent engagement with health and social protection programs (UNICEF, 2020; WHO, 2022).

4.6 Discussion of Findings

This section presents an in-depth discussion of the study's findings from both the qualitative and quantitative components. The analysis integrates the responses from the questionnaire with insights from interviews and focus groups to provide a holistic understanding of knowledge, perceptions, and communication strategies related to STDs/STIs among the target population.

4.6.1 Knowledge, Awareness, and Perceptions of STDs/STIs

The study revealed that awareness of sexually transmitted diseases is high among respondents, with a majority confirming familiarity with HIV/AIDS, Gonorrhea, and Syphilis, while awareness of infections like HPV and Chlamydia was relatively lower. This aligns with studies in sub-Saharan Africa showing high recognition of HIV/AIDS but limited understanding of less publicised STIs (Boateng et al., 2020; Appiah et al., 2022). The quantitative data demonstrated that 85% of respondents had heard of STDs, indicating effective information dissemination through mass media, interpersonal communication, and peer networks.

Respondents correctly identified sexual intercourse, sharing sharp objects, and mother-to-child transmission as primary routes of transmission. However, misconceptions persisted, with a significant minority believing in transmission via casual contact such as kissing or sharing toilets. These findings are consistent with earlier research highlighting the persistence of myths in communities with low health literacy and strong cultural beliefs (Agyei & Osei, 2021; Kenu et al., 2019; Anim et al., 2021). Cultural norms and religious teachings were found to shape perceptions strongly; some respondents noted that religious doctrines influenced willingness to adopt preventive measures like condom use. This is consistent with Addai (2021) and Fiagbey et al. (2022), who emphasised the dual role of religion in either reinforcing or undermining sexual health practices.

The study further revealed that respondents associate symptoms such as genital sores, discharge, painful urination, and rashes with STDs, but gaps in symptom recognition were observed, particularly for asymptomatic infections. This reflects broader public health challenges where low symptom awareness can delay diagnosis and treatment (Nyarko & Boateng, 2019; Roberts et al., 2023). Peer networks and family-based discussions were identified as critical in clarifying misconceptions and increasing understanding, confirming findings by Evans et al. (2025) and

Mavhandu-Mudzusi (2020) regarding the effectiveness of interpersonal communication in low-literacy populations.

The integration of qualitative and quantitative findings indicates that awareness alone is insufficient; cultural, religious, and social norms significantly influence the interpretation and acceptance of STD/STI messages. These structural factors underline the necessity for culturally tailored health communication strategies that incorporate community influencers, trusted leaders, and participatory approaches (UNAIDS, 2023; WHO, 2022).

4.6.2 Effectiveness of Communication Strategies for STD/STI Prevention

The study demonstrated that community-based and interpersonal communication strategies are highly effective when implemented in a culturally relevant and trust-based manner. Quantitative results indicated that more than 70% of respondents agreed that peer education, community durbars, drama performances, and household visits contributed significantly to knowledge improvement and preventive behaviours. These findings resonate with studies by Noar et al. (2020), DePaula et al. (2022), and Amponsah et al. (2021), which emphasised the role of participatory and entertainment-education strategies in enhancing message retention and emphasised behaviour change.

Face-to-face communication emerged as the most trusted medium, with respondents expressing higher confidence in messages delivered directly by health workers, peers, or community leaders. This aligns with Kim et al. (2022) and Asare et al. (2021), who highlighted trust as a critical determinant of message acceptance. Quantitative findings revealed that radio and digital media, while useful for message reinforcement, were less influential on behaviour change without complementary interpersonal engagement. The integration of multiple channels—traditional,

digital, and interpersonal—was associated with higher awareness, myth correction, and preventive action, corroborating research by OECD (2023) and USAID (2019).

Barriers to effective communication included stigma, occupational mobility, irregular programming, and low literacy levels. These obstacles reduce community participation and complicate the adoption of preventive measures, echoing findings by Appiah et al. (2022), Roberts et al. (2023), and Barreto et al. (2024). Respondents noted that non-sexual transmission messages were often overlooked in campaigns, highlighting the importance of comprehensive education that addresses all routes of infection (Rowley et al., 2019; Osei-Tutu et al., 2022).

Monitoring and evaluation were largely informal, relying on attendance, questions asked, and observed behaviours. This approach, while useful for immediate feedback, lacks systematic data collection for long-term strategy refinement. Literature supports the need for structured M&E frameworks to track audience engagement, message comprehension, and behavioural outcomes (UNDP, 2021; Evans et al., 2025; ILO, 2022).

The findings suggest that communication strategies succeed when they are participatory, culturally grounded, trust-based, and delivered through integrated channels. Recommendations from the study emphasise continuous engagement, message simplification, inclusion of non-sexual transmission routes, and strengthened monitoring mechanisms to optimise the impact of STD/STI prevention interventions (WHO, 2023; Rimal & Lapinski, 2023; UNICEF, 2020).9i

4.7 Chapter Summary

This chapter presented a detailed analysis of the data collected for the study, combining both qualitative and quantitative approaches to provide a comprehensive understanding of knowledge, perceptions, and communication strategies for STD/STI prevention within the target communities. The quantitative component analysed responses from 110 participants using

structured questionnaires, while the qualitative component explored in-depth insights from interviews and focus groups with key informants and community members.

The demographic analysis revealed that participants were diverse in age, gender, education level, occupation, marital status, and religion, reflecting the broader socio-cultural context of the study area. Awareness of STDs/STIs was generally high, particularly for HIV/AIDS, Gonorrhea, and Syphilis, while knowledge of other infections, such as HPV and Chlamydia, was relatively lower. Respondents correctly identified major transmission routes, including sexual intercourse, sharing sharp objects, and mother-to-child transmission, though some misconceptions persisted. Cultural, religious, and social norms were shown to significantly influence how individuals interpret, accept, and act upon health messages, underscoring the importance of culturally tailored interventions.

The analysis highlighted the critical role of interpersonal communication, peer education, community durbars, drama, and household visits in facilitating awareness and encouraging preventive behaviour. Trust, message repetition, and community engagement were identified as key drivers of effectiveness. Quantitative results corroborated these findings, showing that multi-channel communication strategies integrating traditional, digital, and community-based approaches were more effective in improving knowledge, dispelling myths, and fostering preventive actions. Barriers such as stigma, occupational mobility, irregular programming, low literacy, and limited coverage of non-sexual transmission routes were consistently reported.

Monitoring and evaluation processes were largely informal, relying on attendance, feedback, and observable behavioural changes. Strengthening structured M&E systems was recommended to improve the effectiveness, refinement, and sustainability of communication strategies. The chapter demonstrated that comprehensive, audience-centred, and culturally grounded communication strategies are essential for promoting STDs/STIs prevention, particularly in low-

resource and informal settings. In essence, the chapter underscores that both the qualitative and quantitative findings are complementary. They collectively indicate that optimising communication interventions requires participatory engagement, multi-channel integration, simplification of messages, cultural sensitivity, and consistent monitoring. These insights provide a solid foundation for the subsequent chapter, which will present the study's conclusions, recommendations, and implications for practice and policy in health communication.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter concludes the study as presented in various sections. The findings of the study were presented, limitations and challenges faced and possible suggestions to future researchers. The concluding part of the study highlighted some recommendations made by the researcher to assist future studies.

5.1 Summary of Key Findings

The study investigated the non-sexual means of STDs/STIs transmission in the Chorkor community, with adolescents and young adults of the community being the main participants of the study and other key informants such as health personnel and peer educators. From the data collected, most of the respondents were male respondents.

From the study, it was observed that community members had knowledge about STDs/STIs transmission through sexual activities, whereas some had little or no idea about other non-sexual means of transmission. While the demographic analysis revealed that participants were diverse in age, gender, education level, occupation, marital status, etc, it reflected a broader socio-cultural context of the study area. Awareness of STDs/STIs was generally high, particularly for HIV/AIDS, Gonorrhea, and Syphilis, while knowledge of other infections, such as HPV and Chlamydia, was relatively lower. Cultural and religious affairs were shown to have an influence on how individuals interpret and accept health messages, as respondents identified the major route of transmission.

The study further highlighted the critical role of interpersonal communication, peer education, community durbars, drama, and household play in facilitating awareness and encouraging

preventive behaviour. Monitoring and evaluation processes were largely informal, relying on attendance, feedback, and observable behavioural changes. Strengthening structured M&E systems was recommended to improve the effectiveness, refinement, and sustainability of communication strategies.

5.2 Conclusion of the study

The study indicates the importance of extensive education on the non-sexual means of STDs/STIs transmission and how communication channels such as drama, community durbars, etc should be intensified to facilitate awareness and encourage preventive behaviours of other means of transmission.

5.3 Challenges of the study.

The study encountered a number of challenges during information gathering. Some challenges encountered during the study include;

1. Some respondents were not willing to give out personal information for personal reasons.
2. Not all questions were answered by participants.
3. Some participants were reluctant during data collection.
4. Some key informants were not ready to be a part of the study and recommended others, thereby causing a delay in data collection.

5.4 Recommendation for future research

Some suggestions for future research include;

1. Researchers should encourage participants to answer all questions.
2. Monitoring and evaluation of communication channels should be looked at in future studies.
3. Researchers should, if possible, focus on the level of education indigens get with regards to STDs/STIs transmission.

5.5 Chapter Summary

This final chapter of the research looked at the concluding words of the research. That is, it consisted of the summary of key findings, which looked at what was said about the study, some challenges the study faced, and recommendations given to future researchers. This study chapter concludes with what the study is about and what can be done in the future.

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APPENDIX I

INTERVIEW GUIDE

Dear Participants, my name is Winnifred Wilson, an M.A. student of Development Communication with the University of Media, Arts and Communication, Institute of Journalism (UniMAC-IJ). I would appreciate your insights into a research study on Communication Strategies in Curbing STDs in the Chorkor community. This is a semi-structured interview which seeks to collect rich, more detailed perspectives by gathering information on how cultural and contextual factors, interpersonal and community-based communication strategies influence preventive behaviours against non-sexual means of STDs/STIs transmission.

Please be assured that all your responses will remain confidential and used solely for this research.

Target Respondents:

- Health professionals and nurses
- NGO staff involved in STDs/STIs communication
- Peer educators
- Community-based health and communication officers

Section A: Background Information

1. Please tell me about your current role and how long you have been working in this community?
2. What specific activities or programs are you involved in related to STDs/STIs prevention and awareness?

Section B: Cultural and Contextual Factors.

3. What cultural beliefs and practices influence community members attitudes towards STDs/STIs and their prevention?

4. Are there any local myths or misconceptions about the transmission of STDs? If yes, kindly share some with us.

5. In your working experience, what are some of the messages that are mostly accepted or rejected when it comes to the non-sexual means of STDs/STIs transmission, and why?

Section C: Interpersonal and Community-Based Communication Strategies.

6. What are some of the roles interpersonal communication plays in influencing STDs prevention when it comes to family discussion, counselling and peer education?

7. Which of communication strategies do you believe is/are most effective for the community? (Group discussions, face-to-face, drama performance, durbars, etc)

8. What are some of the existing barriers that limit the impact of interpersonal or community-based communication efforts?

Section D: Communication Strategies

9. In your view, which communication strategy/ strategies helps during STDs/STIs prevention campaign messages?

10. From your professional perspective, what are some of the evidence which proves that these communication strategies are effective in curbing STDs/STIs?

11. Are non-sexual means of STD/STI transmission included in communication messages? If yes, how were they monitored and evaluated?

Section E: Recommendations

12. What improvements would you suggest for existing HIV/AIDS communication programs, especially concerning non-sexual transmission routes?
13. What kind of training or resources do you believe health professionals and peer educators need to effectively communicate the non-sexual means of STD/STI transmission?
14. In your opinion, how can interpersonal or community-based communication be strengthened in Chorkor?

Section F: Closing

15. Is there anything else you would like to add about HIV/AIDS communication and awareness in this community?

APPENDIX II

QUESTIONNAIRE

Communication Strategies in Curbing STDs in the Chorkor Community.

Dear Respondent, my name is Winnifred Wilson, an M.A. student of Development Communication with the University of Media, Arts and Communication, Institute of Journalism (UniMAC-IJ). I would appreciate your insights into a research study on Communication Strategies in Curbing STDs in the Chorkor community. These questions are designed to collect richer, more detailed perspectives by gathering information on how cultural and contextual factors, interpersonal and community-based communication strategies influence preventive behaviours against non-sexual means of STDs/STIs transmission.

Please be assured that all your responses will remain confidential and used solely for research purposes.

Section A: DEMOGRAPHIC INFORMATION

(Please tick ✓ or fill in where appropriate)

1. Age Group: ☐ (10-15) ☐ (16-25) ☐ (26-30)
2. Sex: ☐ Male ☐ Female
3. Level of Education: ☐ No Formal Education ☐ Basic ☐ Secondary ☐ Tertiary ☐ Other: _____
4. Occupation: _____
5. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabiting
6. Religion: ☐ Christianity ☐ Islam ☐ Traditional ☐ Other: _____

Section B: KNOWLEDGE AND AWARENESS OF STDS *(To measure respondent's understanding of STDs and their causes)*

7. Have you heard of Sexually Transmitted Diseases (STDs)?

   □ Yes □ No

8. Which of the following STDs are you familiar with? *(Tick all that apply)*

   □ HIV/AIDS □ Gonorrhoea □ Syphilis □ Chlamydia □ Genital herpes □ HPV

   □ Don't know any

9. How do you think STDs are transmitted? *(Tick all that apply)*

   □ Unprotected sexual intercourse

   □ Kissing

   □ Sharing sharp objects with infected individual (razors, needles)

   □ Poor hygiene

   □ Mother-to-child during childbirth

   □ Other: _____

10. Which symptoms do you associate with STDs? *(Tick all that apply)*

    □ Genital sores □ Painful urination □ Discharge □ Rash □ Fever □ Don't know

    □ Other:

Section C: CULTURAL AND CONTEXTUAL FACTORS INFLUENCING PERCEPTION AND ACTION ON STD/STI MESSAGES.

(Please indicate your level of agreement with the following statements.)

Scale: 1 = Strongly Disagree | 2 = Disagree | 3 = Neutral | 4 = Agree | 5 = Strongly Agree

No.	Statement	1	2	3	4	5
11.	Cultural norms and beliefs influence how people interpret STDs/STIs-related messages.					
12.	Traditional leaders and elders influence community member's health decision when it comes to STDs/STIs messages.					
13.	Some people believe STDs/STIs are caused by witchcraft, curses and immoral behaviour.					
14.	Religious teaching affect people's willingness to use condoms, contraceptives and other preventive methods.					

15. In your opinion, what specific cultural or social practices make it difficult for people in your community to prevent STDs?

Section D: INTERPERSONAL AND COMMUNITY-BASED COMMUNICATION STRATEGIES

(Please tick the response that best describes your view.)

Scale: 1 = Strongly Disagree | 2 = Disagree | 3 = Neutral | 4 = Agree | 5 = Strongly Agree

No.	Question	1	2	3	4	5
16.	Health education sessions organised for community members has improved awareness about the non-sexual means of transmission.					

17.	Health workers and NGOs include non-sexual means of transmission in their communication messages.					
18.	Community durbars, dramas and outreach programmes include non-sexual means of STDs/STIs transmission in encouraging people to adopt preventive practices.					
19.	Health workers and NGOs provide accessible and reliable information on STD/STI preventing including non-sexual means of transmission.					

20. Which communication strategies (e.g., media, face-to-face, peer groups) have been most effective in your view, and why?

TRANSCRIPT

Section A: Background Information

Interviewer: Please tell me about your current role and how long you have been working in this community.

P1: Okay... uhm, I'm a community health nurse working at the Chorkor Health Centre. I've been here for about seven years now. Most of my work involves attending to outpatients, doing health education, and community outreach, especially on sexual and reproductive health issues.

Interviewer: What specific activities or programs are you involved in related to STDs/STIs prevention and awareness?

P1: I'm mostly involved in the school outreaches, like... errmmm.... community durbars, and the youth group sessions. We do counselling, condom demonstrations, screening when resources allow, and educating people on signs, symptoms, and prevention of STIs. Sometimes we...we....we....work with NGOs for behavioural change programs.

Section B: Cultural and Contextual Factors

Interviewer: What cultural beliefs and practices influence community members' attitudes towards STDs/STIs and their prevention?

P1: Hmm, a lot. Here, many people still believe STDs are punishments for immoral behaviour or spiritual attacks. Some think that once you offend an elder or break certain taboos, the sickness will come as a curse. These beliefs make people hide their conditions. Others rely heavily on herbalists before coming to the clinic.

Interviewer: Are there any local myths or misconceptions about the transmission of STDs?

P1: Oh yes. Some people believe you can get HIV from sharing spoons or cups. Others think you can get gonorrhea from sitting on public toilets. And some even think a mosquito can transmit HIV, which is not true. These things make people panic unnecessarily.

Interviewer: In your working experience, what messages are mostly accepted or rejected when it comes to non-sexual transmission of STDs/STIs?

P1: Messages about transmission through sharp objects are usually accepted. But when we talk about mother-to-child transmission or..errmmm... the fact that HIV can't spread through casual contact, they...they many people in fact, doubt it. They don't easily accept messages that challenge long-held myths.

Section C: Interpersonal and Community-Based Communication Strategies

Interviewer: What roles does interpersonal communication play in influencing STD prevention?

P1: It plays a big role. When we talk to families directly, especially mothers, they open up. Ermm...using many methods also works together than using only one..mhhhh...

Interviewer: Which communication strategies are most effective for the community?

P1: Face-to-face works best here. Group discussions also help because people ask questions. Drama performances attract the youth a lot. Radio programs also work, especially when we use local language.

Interviewer: What are some of the existing barriers?

P1: Stigma is the biggest one. People fear being seen with us or being known to attend STD talks.

Also, low literacy makes some messages difficult to understand. And men rarely attend our programs.

Section D: Communication Strategies

Interviewer: Which communication strategies help most during STDs/STIs prevention campaigns?
P1: Behaviour change communication, peer outreach, and door-to-door sensitization. The community responds well to relatable stories and practical examples.

Interviewer: What evidence shows these strategies are effective?

P1: When we track attendance, we see increases after dramas or durbars. Also, more people come for testing after outreach. Some even return for condoms or counselling.

Interviewer: Are non-sexual transmission messages included? How are they monitored?

P1: Yes, we include them. We check acceptance through feedback forms and follow-up visits. Sometimes we ask people to repeat what they learned to see if they understood.

Section E: Recommendations

Interviewer: What improvements would you suggest for existing communication programs?

P1: We need more community influencers involved. Also, more visual materials in local languages. And we should continuously address myths.

Interviewer: What training or resources do professionals need?

P1: More training on communication skills, updated materials on non-sexual transmission, and logistical support for outreach.

Interviewer: How can interpersonal or community communication be strengthened?

P1: By increasing peer educators, involving religious groups, and using more door-to-door approaches.

Section F: Closing

Interviewer: Is there anything else you would like to add to all that has been said?

P1: Just that stigma is still a big problem. If we don't address it, many people will continue hiding their conditions.

Interviewer: Thank you very much madam, your presence and participation is highly appreciated. Thank you.

TRANSCRIPT

Section A: Background Information

Interviewer: Please tell me about your current role and how long you have been working in this community.

P2: I'm a program officer with an NGO that works on sexual and reproductive health. I've been stationed in Chorkor for four years now, coordinating our STI communication campaigns and youth empowerment projects.

Interviewer: What programs are you involved in related to STDs/STIs prevention?

P2: Mostly behaviour change communication, community workshops, training peer educators, and organizing outreach events like drama performances and durbars.

Section B: Cultural and Contextual Factors

Interviewer: What some of the cultural beliefs influence attitudes toward STDs/STIs?

P2: Many people think STIs only happen to people who live "spoiled lives." So even when someone gets symptoms, they hide. Some also believe STIs are caused by curses or witchcraft. That makes them go to spiritualists before the clinic.

Interviewer: Are there any myths or misconceptions?

P2: Yes.....a number of them. Like...mm.... Some believe HIV can be transmitted through sweat or touching someone. Others think condoms reduce male strength. And many still think urine can cure gonorrhea.

Interviewer: What messages are accepted or rejected?

P2: People accept messages about avoiding sharing blades. But messages about hugging or eating together being safe are often rejected because fear has been deeply rooted over the years.

Section C: Interpersonal and Community-Based Communication Strategies

Interviewer: Role of interpersonal communication?

P2: It's extremely important. When we sit one-on-one with youth, they ask genuine questions they can't ask in public. Family discussions are rare here, but where they exist, they help.

Interviewer: Most effective strategies?

P2: Peer education. Also, community drama. People learn better through stories. And face-to-face interactions create trust.

Interviewer: What are some of the barriers in messages prevention?

P2: Its stigma, low male participation, and misconceptions spread by influential figures like some spiritualists.

Section D: Communication Strategies

Interviewer: Which strategies help most when it comes to campaign messages?

P2: Drama, peer education, and using community influencers. We also use WhatsApp groups for youth.

Interviewer: Are there any evidence of the effectiveness of such campaign messages?

P2: We track attendance, condom uptake, and the number of people who come for voluntary testing after our campaigns. They usually increase.

Interviewer: Are non-sexual means included?

P2: Yes. We stress they are rare but possible, like through sharps. Monitoring is done through pre- and post-session evaluations.

Section E: Recommendations

Interviewer: What improvements do you suggest as a peer educator?

P2: More youth-friendly centres, more male-targeted programs, and continuous myth debunking.

Interviewer: Training needed?

P2: More training on community engagement, up-to-date STI knowledge, and digital communication skills.

Interviewer: How can communication be strengthened?

P2: Build stronger partnerships with churches, mosques, and schools.

Section F: Closing

Interviewer: Anything else?

P2: Yes, we should integrate more culturally sensitive messages. People listen more when we acknowledge their beliefs respectfully.

TRANSCRIPT

Section A: Background Information

Interviewer: Please tell me about your current role and how long you have worked here.

P3: I'm a peer educator working with the youth groups in Chorkor. I've been doing this for about three years now. I talk to young people about safe sex, STIs, and healthy relationships.

Interviewer: What programs are you involved in?

P3: Street outreach, youth club meetings, drama shows, and sometimes school visits. Most of my work is one-on-one counselling.

Section B: Cultural and Contextual Factors

Interviewer: What cultural beliefs influence attitudes toward STDs/STIs?

P3: People here believe STDs mean you're immoral. So once someone hears you have it, they judge you. Some also think STIs are spiritual, so they go for herbs or prayers.

Interviewer: Please tell us some of the local myths on STDs/STIS?

P3: Errmmmm.....Yes. Some believe STIs come from using public toilets. Others think if your partner is faithful, you can't get an STI—which is not true. And some think you can cure STIs by drinking certain mixtures.

Interviewer: Messages accepted or rejected?

P3: Messages about sharps are accepted. Messages that challenge myths—like you can't get HIV through sharing spoons—are rejected by some people.

Section C: Interpersonal and Community-Based Communication Strategies

Interviewer: What roles does interpersonal communication play?

P3: A huge role. Young people ask sensitive questions during one-on-one talks that they won't ask at durbars. Peer pressure is strong here, so peer education works.

Interviewer: What are some of the most effective strategies?

P3: Face-to-face, drama, and group discussions. Youth prefer interactive methods. People love drama here; they laugh, they enjoy it and also remember the lessons. (laughs)

Interviewer: Any barriers?

P3: Stigma, fear of being seen asking questions, and sometimes lack of privacy during sessions.

Section D: Communication Strategies

Interviewer: Which strategies help most?

P3: Peer education and drama. Youth connect more with practical examples.

Interviewer: Evidence of effectiveness?

P3: After sessions, many youth ask for condoms. They also invite us to talk to their friends. We also see more youth visiting the health centre.

Interviewer: Are non-sexual transmission messages included?

P3: Yes, we explain them clearly. We check understanding by asking youth to explain back to us.

Section E: Recommendations

Interviewer: What improvements do you suggest?

P3: More youth-led programs, more materials in Ga language, and more school outreach.

Interviewer: Any training you believe is needed?

P3: Yes...there should be more training on counselling, communication skills, and updated STI information.

Interviewer: What do you think can strengthening communication?

P3: The....the use more youth ambassadors and social media.

Section F: Closing

Interviewer: Any final words for us ma'am?

P3: Yes, stigma is killing people silently. Communication should focus on reducing shame.

TRANSCRIPT

Section A: Background Information

Interviewer: Please tell me about your current role and how long you have been working in this community.

P4: I'm a senior community health officer and I've been working in Chorkor for nine years. My work includes running clinic sessions, supervising outreach teams, and leading community health education programs.

Interviewer: What specific activities or programs are you involved in related to STDs/STIs prevention and awareness?

P4: I handle STI clinic days, support condom distribution programs, coordinate peer educator training, and lead community durbars. I also do a lot of home visits, especially for follow-ups.

Section B: Cultural and Contextual Factors

Interviewer: What cultural beliefs and practices influence community members' attitudes towards STDs/STIs and their prevention?

P4: Many people still believe STDs are curses or spiritual attacks. Some believe that if you offend someone or break a taboo, the sickness will come as a punishment. These beliefs make people delay treatment because they first try spiritual interventions.

Interviewer: Are there any local myths or misconceptions about the transmission of STDs?

P4: Oh yes. Some say HIV can be gotten from sharing a basin of water during bathing. Others say you can get gonorrhea from public toilets. Some even believe that wearing the clothes of an infected person can give you an STI.

Interviewer: What messages are mostly accepted or rejected regarding non-sexual transmission?

P4: Messages about razor blades and needles are easily accepted. But when we tell them HIV doesn't spread through casual contact like hugging or sharing a bowl, many disagree. They have held onto these fears for many years.

Section C: Interpersonal and Community-Based Communication Strategies

Interviewer: What roles does interpersonal communication play in influencing STD prevention?

P4: It plays a huge role. People trust one-on-one conversations more. They feel free to ask private questions. Peer educators especially help the youth understand things better because they relate on a personal level.

Interviewer: Which communication strategies are most effective for the community?

P4: Community drama, face-to-face talks, and small group discussions. People prefer stories and examples they can relate to. Public announcements also work when done in local language.

Interviewer: What are some existing barriers?

P4: Stigma, gender norms, and lack of privacy during community sessions. Some men don't want to be seen listening to STI education because they think people will suspect them.

Section D: Communication Strategies

Interviewer: Which communication strategies help during STDs/STIs prevention campaigns?

P4: Peer outreach, storytelling, and drama-based communication are the most effective. Door-to-door sensitization also helps a lot.

Interviewer: What evidence shows these strategies are effective?

P4: We see increases in clinic attendance, especially for STI testing, after our programs. People also ask more questions and request condoms during outreach sessions.

Interviewer: Are non-sexual transmission messages included?

P4: Yes, we include them. We monitor understanding through feedback sessions and by asking participants to summarize what they learned.

Section E: Recommendations

Interviewer: What improvements would you suggest?

P4: We need more consistent outreach and more partnerships with community leaders. Also, visual teaching materials in the local language would help a lot.

Interviewer: What training or resources are needed?

P4: Some resources I can...e.r...mm....come with are....updated training on STI trends, more communication tools, and transport for outreach teams.

Interviewer: How can communication be strengthened?

P4: By involving churches, mosques, and local influencers. They shape opinions here.

Section F: Closing

Interviewer: Anything else?

P4: We must keep addressing myths. They make people fear the wrong things and ignore the real risks.

TRANSCRIPT

Section A: Background Information

Interviewer: Please tell me about your current role and how long you have been working here.

P5: I'm a community mobilization assistant with an NGO, and I've been working in Chorkor for five years. I support mobilizing residents for STI awareness campaigns and trainings.

Interviewer: What specific activities are you involved in related to STDs/STIs prevention?

P5: Mobilizing for durbars, supporting peer educators, organizing group discussions, and distributing condoms. I also help coordinate the youth clubs.

Section B: Cultural and Contextual Factors

Interviewer: What cultural beliefs influence attitudes toward STDs/STIs?

P5: Many people believe STDs are due to immoral lifestyles, so if someone gets it, the community labels them immediately. Some also think certain STIs are caused by witchcraft or curses, so they hide their symptoms.

Interviewer: Any local myths?

P5: Yes. People believe you can get HIV from sharing spoons or from sweat. Others think if you are faithful, you can never get an STI. These myths make people too relaxed about their sexual health.

Interviewer: Messages mostly accepted or rejected?

P5: People accept messages about transmission through sharp objects. But they reject messages that say sharing food or toilets is safe. Some believe those are lies to reduce fear.

Section C: Interpersonal and Community-Based Communication Strategies

Interviewer: What roles does interpersonal communication play?

P5: A big role. Most people won't ask questions in public, but privately they open up. Counselling helps people understand their own sexual behaviour better.

Interviewer: Most effective strategies?

P5: Community drama, peer outreach, and small group discussions. People enjoy interacting, not just listening.

Interviewer: Barriers?

P5: Stigma, shame, and fear of being judged. Also, some young men imitate their peers and reject condoms because of peer pressure.

Section D: Communication Strategies

Interviewer: Which strategies help during campaigns?

P5: Door-to-door sensitization, drama, and peer-led messaging. They engage the youth well.

Interviewer: What evidence shows effectiveness?

P5: After our programs, we usually see more young people coming for testing and counselling. Some also ask for more condoms.

Interviewer: Are non-sexual transmission messages included?

P5: Yes. We talk about sharps, mother-to-child, and blood transfusion. We check understanding through follow-up questions.

Section E: Recommendations

Interviewer: What improvements do you suggest?

P5: More campaigns targeting men and traditional leaders. They influence community beliefs a lot.

Interviewer: Please what are some of the trainings needed?

P5: More capacity-building for peer educators—counselling, communication, and updated STI information.

Interviewer: Strengthening communication?

P5: We...we should use more local language and storytelling methods. They work best here.

Section F: Closing

Interviewer: Any closing remarks for us?

P5: Yes, stigma is still the biggest barrier. People hide instead of seeking help.

TRANSCRIPT

Section A: Background Information

Interviewer: Please tell me about your current role and how long you have been working in this community.

P6: I'm a community health volunteer and also a peer educator. I've been working here for six years. I support the health centre with outreach, education, and mobilization.

Interviewer: What specific activities are you involved in related to STDs/STIs prevention?

P6: Educating youth, organizing group discussions, helping distribute condoms, and supporting the nurses during community durbars. I also handle youth outreach in fishing areas.

Section B: Cultural and Contextual Factors

Interviewer: What cultural beliefs influence attitudes toward STDs/STIs?

P6: The community believes STDs are shameful and only happen to "wayward" people. This makes people hide symptoms. Some also believe men shouldn't go for STI testing because it makes them look weak.

Interviewer: Are there local myths or misconceptions?

P6: Yes. Many still think sitting on public toilets gives you STIs. Some also think using a condom shows you don't trust your partner. There's also a myth that spiritual attacks can cause sores.

Interviewer: Messages mostly accepted or rejected?

P6: Messages about safe blade use are accepted. But many reject messages saying STDs can't be spread through sharing bowls or through sweat. They believe those myths too strongly.

Section C: Interpersonal and Community-Based Communication Strategies

Interviewer: What roles does interpersonal communication play?

P6: It helps young people understand the real risks. When we talk privately, they ask questions they can't ask in front of adults. Peer influence is strong here, so peer education works best.

Interviewer: Most effective communication strategies?

P6: Drama, face-to-face interactions, and peer talks. The youth prefer interactive sessions, not lectures.

Interviewer: Barriers?

P6: Stigma, lack of time, and sometimes community members think we are there to expose them. Also, some men don't cooperate.

Section D: Communication Strategies

Interviewer: Which strategies help during campaigns?

P6: Peer education, storytelling, and demonstrations like condom use. Door-to-door also works because people feel comfortable.

Interviewer: Evidence of effectiveness?

P6: After our sessions, people come forward for condoms and ask for more information. We also see increases in clinic visits for STI screening.

Interviewer: Are non-sexual transmission messages included?

P6: Yes, we talk about sharps, blood, and mother-to-child. We check understanding by asking them to repeat what they learned.

Section E: Recommendations

Interviewer: What improvements would you suggest?

P6: More programs at the beaches and fishing areas. And regular campaigns—not only during special events.

Interviewer: Training or resources needed?

P6: More training on counselling skills and more educational materials, especially visuals.

Interviewer: How can communication be strengthened?

P6: Use more peer ambassadors, involve chiefs and opinion leaders, and increase outreach frequency.

Section F: Closing

Interviewer: Anything else?

P6: Yes, stigma and silence are weakening our efforts. We need to address these directly.

TRANSCRIPT

Section A: Background Information

Interviewer: Please tell me about your current role and how long you have been working in this community?

P7: "I am a Community Health Communication Officer, and I have been assigned to Chorkor for the past six years. My role involves community mobilisation, conducting health talks, organising durbars, and monitoring how people are responding to our health messages. I work closely with peer educators, nurses, and NGO teams to make sure our communication reaches the right people."

Interviewer: What specific activities or programs are you involved in related to STDs/STIs prevention and awareness?

P7: "I mainly handle the planning and implementation of community forums, school outreaches, and house-to-house sensitisation on STDs and HIV. I also supervise some of the peer educators and collect data on turnout and feedback from the community. Part of my work is also listening to concerns people raise and helping the team adjust our messages."

Section B: Cultural and Contextual Factors

Interviewer: What cultural beliefs and practices influence community members' attitudes towards STDs/STIs and their prevention?

P7: "In this community, many people still think STDs are punishments for immoral behaviour. So, instead of seeing it as a health issue, they see it as a moral failure. That belief makes them

hide symptoms or deny they are sick. Some also think that once you pray or cleanse yourself, the illness will disappear, so they delay coming to the clinic."

Interviewer: Are there any local myths or misconceptions about the transmission of STDs? If yes, kindly share some with us.

P7: "Yes, many misconceptions. Some people believe STDs can be spread through witchcraft or curses. Others think you can get it from using a public toilet or sharing a towel. We also hear people saying you can get HIV by sitting close to someone or eating from the same bowl. These myths make it hard for them to believe our medical explanations."

Interviewer: In your working experience, what messages are mostly accepted or rejected when it comes to the non-sexual means of STDs/STIs transmission, and why?

P7: "People usually accept messages about mother-to-child transmission. They have seen examples in the community, so they believe that. But they mostly reject messages about sharing sharp objects or transmission through blood contact. They don't see the risk because they share razors and needles all the time for haircuts and piercings. They think we are exaggerating when we warn them."

Section C: Interpersonal and Community-Based Communication Strategies

Interviewer: What roles does interpersonal communication play in influencing STD prevention through family discussion, counselling, and peer education?

P7: "Interpersonal communication helps people ask questions freely. During house-to-house visits, people are more honest than when we use a megaphone. Peer educators also help a lot—youth talk to them because they see them as friends. Some mothers now come to us for advice on talking to their children. So interpersonal communication helps break the fear and shame."

Interviewer: Which communication strategies do you believe are most effective for the community?

P7: "Face-to-face communication is the best. After that, group discussions in the community, especially when we do them in Ga language. Drama performances also work well because they show real-life situations. People love durbars, but sometimes they come only for the entertainment, not the information."

Interviewer: What are some of the existing barriers that limit the impact of interpersonal or community-based communication efforts?

P7: "The main barriers are stigma, fear of judgment, and time constraints. People don't want to be seen talking about STDs in public. Also, some men refuse to attend our programs because

they believe sexual health is a 'women's issue'. Another barrier is misinformation spread by peers, especially among the youth."

Section D: Communication Strategies

Interviewer: Which communication strategy or strategies help during STD/STI prevention campaigns?

P7: "The strategies that help most are peer education, drama performances, and small group sensitisation. Also, using community influencers—like market queens and youth leaders—helps us reach more people because the community already trusts them."

Interviewer: From your professional perspective, what evidence shows that these communication strategies are effective in reducing STDs/STIs?

P7: "We see improvements in the number of people coming for testing. During drama sessions, more youth approach us afterward to ask questions. Also, the peer educators send in reports showing behaviour change—for example, more young men asking for condoms. And we see fewer cases of untreated STDs compared to previous years."

Interviewer: Are non-sexual means of STD/STI transmission included in communication messages? If yes, how were they monitored and evaluated?

P7: "Yes, they are included. We talk about sharing sharp objects, blood contact, and mother-to-child transmission. We monitor them through feedback from the peer educators and by observing whether behaviour is changing—for instance, fewer shared shaving blades at the community barber shops."

Section E: Recommendations

Interviewer: What improvements would you suggest for existing programs, especially regarding non-sexual transmission routes?

P7: "We need more practical demonstrations. Telling people isn't enough. We should show them how transmission happens. Also, we need more community champions who can talk about their experiences to reduce fear and shame."

Interviewer: What training or resources do health professionals and peer educators need to effectively communicate non-sexual means of transmission?

P7: "They need updated training manuals, more visual aids, and refresher workshops. Peer educators also need allowances and transportation money. Sometimes they stop because they can't sustain the work."

Interviewer: How can interpersonal or community-based communication be strengthened in Chorkor?

P7: "We should involve more local leaders, including pastors, imams, and chiefs. When they speak, people listen. We also need regular community forums, not just when there is funding."

Section F: Closing

Interviewer: Is there anything else you would like to add about HIV/AIDS communication and awareness in this community?

P7: "Just that we need to talk about STDs more openly. If we stop treating it as a taboo, people will come out earlier for help. Communication must continue and not only when a project comes."

TRANSCRIPT

Section A: Background Information

Interviewer: Please tell me about your current role and how long you have been working in this community?

P8: "I work with an NGO as a peer educator but focuses on sexual and reproductive health education. I have been stationed in Chorkor for about four years now. My main role is coordinating community outreach programs and supervising the volunteers who help with our STI and HIV awareness activities."

Interviewer: What specific activities or programs are you involved in related to STDs/STIs prevention and awareness?

P8: "We run school awareness campaigns, market sensitisation, peer educator training, and free screening events. I also handle message development, making sure our communication materials are culturally appropriate. We also distribute condoms and educational leaflets during our outreach."

Section B: Cultural and Contextual Factors

Interviewer: What cultural beliefs and practices influence community members' attitudes towards STDs/STIs and their prevention?

P8: "Cultural beliefs here are very strong. Most people believe STDs only happen to those who are promiscuous. That belief makes many people avoid early testing. Also, in this community, sex is not openly discussed. Parents rarely discuss sexual health with their children, so young people depend on friends for information—which is often wrong."

Interviewer: Are there any local myths or misconceptions about the transmission of STDs? If yes, kindly share some with us.

P8: "Oh, many. Some believe that you can get HIV from mosquito bites. Others think that bathing with hot water after sex can prevent infection. One common myth is that STDs can be cured by traditional herbs alone. Because of that, people delay visiting the clinic and sometimes make the condition worse."

Interviewer: In your working experience, what messages are mostly accepted or rejected regarding non-sexual means of STDs/STIs transmission, and why?

P8: "Most people accept mother-to-child transmission. They've heard it many times. But messages about sharing sharp objects or getting infected from blood spills are usually rejected. They think we are making it up because they don't see the immediate danger. They say, 'We have been sharing razor blades all our lives, and nothing has happened.'"

Section C: Interpersonal and Community-Based Communication Strategies

Interviewer: What roles does interpersonal communication play in influencing STDs prevention (family discussion, counselling, peer education)?

P8: "Interpersonal communication is everything. It helps create trust. During one-on-one counselling, people share things they will never say in a group. Parents who receive counselling sometimes begin to talk to their children. Peer education also works because the youth relate better to someone their age."

Interviewer: Which communication strategies do you believe are most effective for the community?

P8: "Drama and group discussions work very well here. Drama, especially, grabs attention and allows us to show consequences in a way that is not direct or confrontational. Face-to-face sensitisation is also effective because people can ask questions freely."

Interviewer: What barriers limit the impact of interpersonal or community-based communication efforts?

P8: "The barriers include stigma, cultural silence, and lack of privacy. When we organise community meetings, some people avoid attending because they fear others will think they have an STI. Also, misinformation spreads faster than the correct information. And sometimes, due to busy schedules, people don't stay long enough to listen."

Section D: Communication Strategies

Interviewer: In your view, which communication strategies help during STDs/STIs prevention campaign messages?

P8: "The most helpful strategies are peer education, community drama, and targeted small-group meetings. Using local languages, especially Ga, is also crucial. We also use WhatsApp groups to reach some of the youth."

Interviewer: From your professional perspective, what evidence proves these communication strategies are effective in curbing STDs/STIs?

P8: "We measure attendance, increased clinic visits, and participation in our follow-up programs. After drama events, we always see an increase in young people coming to ask questions. The clinic also reports that more people come for testing after our major outreach events. That is clear evidence."

Interviewer: Are non-sexual means of STD/STI transmission included in communication messages? If yes, how were they monitored and evaluated?

P8: "Yes, we include them. We use posters, community discussions, and demonstrations. Evaluation is mainly through feedback from community leaders, questionnaires we share during programs, and observing behaviour change—for example, fewer shared razor blades in barber shops after sensitisation."

Section E: Recommendations

Interviewer: What improvements would you suggest for existing HIV/AIDS communication programs, especially regarding non-sexual transmission routes?

P8: "We need to emphasize practical demonstrations. People understand better when they see. Also, we should involve more religious leaders because they influence many community beliefs."

Interviewer: What training or resources do health professionals and peer educators need to communicate effectively about non-sexual transmission?

P8: "Updated training modules, more visual aids like flipcharts, and logistics like megaphones and projectors. Peer educators also need consistent training and motivation—many stop because they don't have enough resources."

Interviewer: How can interpersonal or community-based communication be strengthened in Chorkor?

P8: "By conducting more regular house-to-house visits and not waiting for big events. We also need to engage the youth more intentionally with activities that interest them, like sports events with embedded sensitisation."

Section F: Closing

Interviewer: Is there anything else you would like to add about HIV/AIDS communication and awareness in this community?

P8: "I just want to add that communication must be continuous. When we stop educating, misinformation takes over. People need frequent reminders because of the cultural beliefs here."

TRANSCRIPT

Section A: Background Information

Interviewer: Please tell me about your current role and how long you have been working in this community?

P9: "I am a health officer here in Chorkor with over 4 years' experience. I'm more involved with patience care but do participate in outreaches organised by the health care facility."

P10: "And I'm also with an NGO with 8-10 years of experience here in the community. By working with other institutions, we implement campaign awareness and monitor its outcomes."

Interviewer: What specific activities or programs are you involved in related to STDs/STIs prevention and awareness?

P10: "We do school visits, street outreach, and small youth group sessions. Sometimes we join the health centre staff during community campaigns. I also help distribute condoms and demonstrate how they are used properly. Many young people prefer talking to us instead of going to the clinic, so we act as a bridge."

Section B: Cultural and Contextual Factors

Interviewer: What cultural beliefs and practices influence community members' attitudes towards STDs/STIs and their prevention?

P9: "The biggest issue is that people still think STDs are a sign of living a bad life. Once somebody gets sick, the first assumption is that they are irresponsible. So, because of that, people don't want to check early or tell anyone. Also, most homes don't talk about sex. Parents feel shy, so many youth learn from friends or social media."

Interviewer: Are there any local myths or misconceptions about the transmission of STDs? If yes, kindly share some with us.

P10: "Yes, plenty. Some people think HIV can be transmitted through handshakes or sharing cups. Others believe that when you sleep with a virgin, it will cure STDs. And then there's the one where people say bar soap can 'kill the disease' if you bathe right after sex. These myths make prevention very difficult."

Interviewer: In your working experience, what messages are mostly accepted or rejected regarding the non-sexual means of STDs/STIs transmission, and why?

P10: "People accept mother-to-child transmission and blood transfusion messages. But they reject the idea of sharing sharp objects being risky because they see it as normal practice. When we tell them it's dangerous, some say, 'We've been doing it for years, nothing has happened.' So convincing them is hard unless someone they know gets infected."

Section C: Interpersonal and Community-Based Communication Strategies

Interviewer: What roles does interpersonal communication play in influencing STDs prevention, especially in family discussion, counselling, and peer education?

P10: "Interpersonal communication is very powerful. Many youth tell me things they won't tell their parents or the nurses. Because I am close to their age, they trust me. Peer discussions help reduce fear, and during counselling we correct wrong information. If you talk to them one-on-one, they ask more personal questions without feeling embarrassed."

Interviewer: Which communication strategies do you believe are most effective for the community?

P9: "Drama works very well, especially during community events. It draws attention. After drama performances, we get many questions. Face-to-face sessions also work because people open up. And for the younger ones, social media and WhatsApp groups are effective."

Interviewer: What barriers limit the impact of interpersonal or community-based communication efforts?

P9: "The big barrier is stigma. If we organise a group discussion, some people don't want to attend because they think others will assume they have an STI. Also, time is a problem; many residents work long hours, especially fishermen and market women. And sometimes people don't trust the information because they rely more on what their peers say."

Section D: Communication Strategies

Interviewer: In your view, which communication strategy or strategies help during STDs/STIs prevention campaign messages?

P9: "Peer education and group discussions help a lot. Community durbars also reach many people. Using Ga to explain things makes people understand better. And visual aids like pictures or demonstrations catch attention more than just talking."

Interviewer: From your professional perspective, what are some of the evidence that proves these communication strategies are effective in curbing STDs/STIs?

P10: "Sometimes after a session, young people come back to tell me they went for a test or started using condoms. During our follow-ups, we find that more youth join the WhatsApp groups. And the clinic reports more walk-ins after our outreach, especially the drama events."

Interviewer: Are non-sexual means of STD/STI transmission included in communication messages? If yes, how were they monitored and evaluated?

P10: "Yes, we include them. We talk about sharing needles, razor blades, and blood contact. We evaluate by checking how many people can recall the messages during follow-ups. Sometimes we ask questions in the WhatsApp groups to see what they remember."

Section E: Recommendations

Interviewer: What improvements would you suggest for existing HIV/AIDS communication programs, especially concerning non-sexual transmission routes?

P9: "We need to use more demonstrations, like showing how sharing blades can be risky. Also, regular sensitisation should happen. Not only during big events. And more youth clubs should be formed so that messages spread faster among the young ones."

Interviewer: What kind of training or resources do you believe health professionals and peer educators need to communicate non-sexual transmission effectively?

P10: "Peer educators need more training materials and up-to-date information. Many volunteers lack handouts or visual tools. We also need simple videos or graphics we can share online. Transport money is also important because sometimes reaching people is difficult."

Interviewer: In your opinion, how can interpersonal or community-based communication be strengthened in Chorkor?

P10: "By involving more community leaders and parents. When leaders speak, people listen. Also, we must build more youth-friendly spaces where young people feel safe to talk."

Section F: Closing

Interviewer: Is there anything else you would like to add about HIV/AIDS communication and awareness in this community?

P9: "I just want to say that the youth need more attention. Many of them don't know the truth about STDs, and they are shy to ask. If we keep talking to them in ways they understand, things will change."

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