SOCIAL MASKS AND DRAMATURGY IN DIABETES HEALTH CAMPAIGNS IN LOW RESOURCED AND "CLOSED" COMMUNITIES

Dr Lovie Edwin Seru*

Abstract

Diabetes campaigns in remote villages of Botswana bring together cultural groups which come from completely different life worlds into communication events: the urbanized, educated and "rich" diabetes health promotion officials and the poor and illiterate remote villagers. Based on persona, a concept that represents the construction and employment of social roles and identities to mediate between the inner self and external social world, were expected to make conscious decisions to "fashion" their interpersonal communications around remote villagers' cultural, communication and discursive practices. Grounded on the premise that different cultures have different communication practices, different sense making practices, and different ways of seeing reality, the objective of this study was to find out the personae that diabetes health promoters adopt when communicating diabetes campaign information to remote villagers. Using a participant observation of diabetes public wellness talks and semi-structured interviews, the findings show that diabetes health promotion practitioners adopt social masks which are quite different from, and are polar opposites of their own interpersonal communication practices when disseminating diabetes health messages in remote areas. They adopt verbal behaviours, non-verbal behaviours and contextual influences that shape conversations and narratives in remote villages and incorporate them into their interpersonal communication.

Keywords: **persona, remote villagers, diabetes, campaign messages, social constructionism**

* **University of Botswana**

Introduction

Diabetes is an increasing cause of morbidity and mortality in Botswana (Mokgweetsinyana, 2011). Research findings indicate that the processes of rural-urban migration and lifestyles changes are certainly increasing the prevalence of diabetes in remote rural area settlements (Gill et al.2008). It is estimated that Botswana experiences 4.1 percent diabetes prevalence rates (Mokgweetsinyana, 2011). This figure shows that diabetes in Botswana is ominous and it is higher than the overall estimated diabetes prevalence in sub-Saharan Africa which stands at 3.1 percent (Gill et al. 2009; Mokgweetsinyana, 2011). Indeed official figures about diabetes prevalence rates in sub-Saharan Africa show that Botswana is the most affected country in sub-Saharan Africa (Gill et al. 2009).

A key factor that has been identified as contributing to increased prevalence of diabetes in Botswana is urbanization(Sabone, 2008). Although Botswana's remote rural area communities are still dependent on agriculture for their livelihood, and there are no industries in remote rural areas, there are close ties between urban dwellers and remote villagers which inevitably lead to the encroachment of modern life into remote rural areas (Norr, Tlou & Matshediso, 2004). Many people in urban centres migrated from rural areas in search of jobs and better health and educational opportunities. While in urban areas, those people keep in contact with their relatives in rural areas. On account of the close ties between urban dwellers and the villagers, and the influence of modern life, there is an increase in consumption of foods high in fats and refined carbohydrates in remote rural areas (Sabone 2008; Koosaletse 2002). There is a high number of people who move into the cities and back into rural areas bringing tobacco products, alcohol and foods high in fats which contribute to increased prevalence of diabetes in remote area settlements.

Through observation and interaction with the villagers, it emerged that many families have members who work in the cities and other urban centres, and that those family members periodically bring alcohol, cigarettes and foods high in fats and refined carbohydrates to remote villages. Also, there are general dealers and kiosks in the villages which sell alcohol, cigarettes and many such unhealthy foods. As a result, there is a greater choice of food available in shops than existed many years ago in remote rural settlements (Koosaletse 2002).

It is against this backdrop that this paper has been developed. It appears that if there are no interventions, the prevalence rates figure might double by 2030. In the light of this, this study aimed to build knowledge about effective management and prevention communication strategies that can be used in low resourced and "closed" communities without print or electronic literacy to fight the spread of diabetes, hence investigating the personae that diabetes health promoters used to communicate diabetes health promotion messages. As suggested by the concerns and objective of this study,the author of this study advocates for proper methodological and contextual considerations in communicating diabetes health campaign information to remote villagers, who incidentally constitutes the bulk of the country's population (Majelantle, 2011; Hanemann, 2005).

In Botswana, diabetes health campaigns in remote villages are planned, organized and implemented by the Diabetes Association of Botswana (DAB) and the Ministry of Health (MoH) officials. The MoH is a government health department, while the DAB is a not-for-profit, voluntary, apolitical and autonomous Non-Governmental Organization (NGO). As such, diabetes health promoters comprises mainly urban-based educated Batswana, foreigners and some educated village-based health professionals such as local nurses and family Welfare Educators (FWE). This is the main problem that prompted the inception of this paper.While diabetes health promoters are the social and educated elites, and have varied and advanced means of sharing and acquiring information, including having access to modern communication systems which afforded them social and economic advantages, remote villagers on the other hand are by and large illiterate, poor and mainly acquire and share information through interpersonal means of communication. Given problems that usually occur when people from different social backgrounds communicate, I speculated that the socio-cultural differences between diabetes health promotion practitioners and remote villagers could serve as major hindrances to the successful dissemination of diabetes campaign messages. Because of their relatively higher social and economic status and academic credentials, I also speculated that contrary to the dictates of the social constructionist paradigm, those diabetes health promoters could be disseminating diabetes campaign messages from the ambit and assumptions of their own cultures, as well as their relative and apparent expert and elitist positions with little regard for the villagers' unique characteristics and lifestyles.

In the light of this assumption, the objective of this paper was to explore the personae that diabetes health promoters who come from a completely different life-world adopt to communicate diabetes health messages to remote villagers.

The exploration of the personae that diabetes health promoters adopt therefore started from the premise that as human beings, we constantly perform different social roles, conceal our true identities and fake the identities of the people whose life worlds we want to transcend and fit into (D'Cruz 2014). In the light of this, this paper serves to authenticate the argument that in order for diabetes health promoters to effectively communicate diabetes health messages to remote villagers, they have to engage in performative acts that would enable them to be accepted and understood by the villagers. In short, they have to assume the characters of the villagers, and dramatize impression management, something D'Cruz (2014) and Marshall (2014) call a persona.

Persona

The word persona has been derived from the Latin word for theatrical mask (D'Cruz, 2014) and for its everyday usage it refers to assumed character, social role or the person's character that is perceived by others (D'Cruz, 2014). D'Cruz (2014) further argues that persona is a kind of mask that people "wear" to make a definite impression upon others and to conceal their own true nature. It is a character we adopt, display or assume (Marshall 2014). As these explanations show, persona is predicated on "deception",or in the words of Marshall (2014)and D'Cruz(2014)"inauthenticity" and "fiction". Goffman (1969) arguesthatwhen individuals play these "deceptive roles", they covertly request their observers to take seriously the impressions they display. They clandestinely request their audiences to believe that the characters they see actually possess the attributes they are displaying (Goffman, 1969). As Marshall (2014) also suggests, although the characters or personages are not real, they have a clear relationship with the real public culture. While through performance it may seem what is being seen or heardis an expressive extension of the characteristics of the performer, it often happens that the performance mainly serves to portray the characteristics of the task being performed and not of the performer (Goffman, 1969).

Persona could also be viewed as a conscious repression of one's identities in order to display social roles and characters that are in synch with the prevailing social order. This kind of repression is made possible by the fact that some identities are socially constructed. As Elliott (2014) confirms, some identities are established through personal actions and choices, and the patterning of thoughts, dispositions, feelings and desires and modelling subjective experiences in line with the social settings of daily life. Elliott (2014) illustrates the point about the patterning of actions and dispositions in response to different social settings when he opines that:

> The way in which an individual acts in the presence of family members or loved ones is likely to be rather different from encounters with, say, work colleagues or sporting partners. From family, school and work to shopping, community associations or surfing the Internet: all these social fields summon forth, and through them we construct, different sorts of self.

The influence of social setting or front as Goffman (1969) calls it, in the fashioning of individual disposition and actions demonstrates that at the core of the adoption of a persona is the navigation of personal and public life or relation between self and society. Elliott (2014) confirms this assertion when he argues that identity is constructed through predetermined actions and choices, the patterning of thoughts, dispositions, and feelings and desires to align them to the prevailing social order. Elliott (2014) further argues that as human beings we act out or perform particular roles in our relationships with others, and that we have an awareness of the varying identities we want to adopt as we move from one social setting to another.

As shown above, diabetes health promoters in Botswana have their own individual or real identities which vary diametrically from the identities of remote villagers whom they want to reach with diabetes health information. There is anarray of literature which specifies that for information to benefit its target audiences, the communication processes for the dissemination of that information should identify with and incorporate the cultural expressions, health beliefs and communication practices of target audiences (Airhihenbuwa, 1995;Dutta, 2008;Ford & Yep, 2003). In conducting this study, I was therefore interested in finding out what particular roles did diabetes health promoters act out in order to disseminate with real benefit diabetes campaign

messages to remote villagers who were non-elite and whose values and cultural expressions were different. Because of the different values and cultural orientations different people in different settings embrace, there is an argument that the constructed identities are incessantly bombarded with shifting cultural stimuli and fragmenting social attributes (Elliott, 2014). In the light of this argument, I wanted to find out how the cultural orientations of remote villagers shaped the communication processes of the elite diabetes health promoters.

Marshall (2014) argues that persona addresses the fabrication of roles to achieve particular purposes. Goffman (1969) also raises the same point when he suggests that the performance that an individual does, and the show that they put on are done for the benefit of other people. This entails that thepersonas that diabetes health promoters adopt should not be viewed negatively as mere objects of deluding the villagers for purposes of self-interest or private gain. On the contrary, they should be viewed as having been influenced and adopted with good intentions and desirable purposes of changing the villagers' unhealthy behaviours and help them survive or preclude the development of the dreaded diabetes condition.In short, even if the performances might not have been real, they should clearly portray the villagers' public culture.In other words, they should be extensions into the public world. As Goffman(1969) further asserts, individuals may deceive other people for what they consider to be their own good and the good of those people. My aim in this study was therefore to establish how diabetes health promoters "deceptively" lured the villagers who have different cultures and communication processes into accepting and conceptualising their diabetes health messages.

The discussion above shows that in a broader sense, persona denotes articulation of repertoires of actions, identification, socialisation and cultural practices through which new inauthentic identity positions are developed. Hetherington (1998) argues that all these issues-actions, identification and cultural practicesare linked to theatricality in that they are embodied and enacted through performance. Hetherington (1998) uses theatricality here as a metaphor to mean the social construction of self through performances and creation of personae. In the same vein as Goffman (1969) depicts presentation of the self as "stage managed", Hetherington (1998) also arguesthat the presentation of the self is closely associated with impression management, coordination of behaviour and role assumption. In this way, this theatricality is enacted.Hetherington (1998) contends that while this theatricality is being played out, the realself

remains outside such practices and inaccessible to audiences who will then believe that the characters they see actually possess the attributes they are displaying.

Methods

To unearth the personae that diabetes health promoters adopt when communicating diabetes campaign messages to the villagers, two methods were used: participant observation a.k.a hanging out and semi-structured interviews.

The participant observation method was employed to uncover the communication processes of diabetes health promoters. It involved observing public campaigns in two remote area communities where diabetes campaigns were held. It also involved observing diabetes wellness talks every morning in the clinics in those two remote communities. During such times, the researcher observed and listened to what was said about various issues, including health in general and diabetes in particular. The primary aim of observing diabetes health campaigns and wellness talks was to study the communication processes of diabetes health promotion practitioners. Those communication processes were studied in terms of whether or not there were personae that were adopted to align the communication processes to the socio-cultural and political contexts of remote villagers. As subtly detailed in the previous section, the focus of this research was Intercultural Communication and this was born out of the realization that remote villagers had socio-economic and political circumstances which were different from those of the people who communicated diabetes health messages to them. Participant observation was therefore used to enable the researcher to find out how the ways in which diabetes health promoters engaged remote villagers in dialogical processes and represented diabetes education messages rhetorically and in print, were embedded in and influenced by the cultural codes, meanings and values of remote rural area people. Learning from Lupton (1992), these cultural codes include: communication practices, community rules and traditions, health beliefs, socio-economic practices, gender roles, and many other factors that make up the framework of their everyday living. For this study, the code that was investigated was communication practices. Specifically, the observation of diabetes public wellness talks aimed to answer the following related but separated questions:

- What were the specific communication actions and discursive practices (personae) of diabetes health practitioners? In other words, how were diabetes messages produced and made to be received by remote area people?
- From whose cultural ambit and assumptions were diabetes campaign messages communicated? Was it from the expert position (elitism) of diabetes health promotion practitioners or was it from the cultural, political and social orientations of remote villagers?

Given that not all aspects of the communication of diabetes messages could be learnt through observation, a semi-structured interview was also used. Interview participants were purposively and randomly selected and they included some opinion leaders in the villages and Diabetes Association and Ministry of Health officials.The village informants were used to confirm or refute Diabetes Association and Ministry of Health officials' responses to interview questions on how they endeavoured to align the communication processes with villagers' socio-cultural orientations and practices.

Prior to conducting the interviews, a pilot study was carried out in order to ensure that the questions were clear and suitable, and to avoid difficult experiences where respondents might request clarifications of questions or find them offensive. The pilot study was conducted with two diabetes health promotion practitioners and two village key informants. These did not form part of the final population of semi-structured interviewees. Despite the interviews having been semi-structured, an effort was made to ask respondents the same questions. Interview questions were asked as they had been worded and in the order that they appeared in the interview guide to enable ease of comparison and analysis of interview responses. All the interviews were recorded on a voice recorder and were later transcribed and analysed.

Data Analysis

Given the qualitative nature of this study, data was produced in the form of observation notes and narratives of interview participants' opinions. As a result, data analysis was largely interpretative, analytical and descriptive and was mainly based on observer impressions. To put it differently, data was examined and interpreted by forming impressions and reporting those impressions using the coding guidelines prescribed by the grounded theory (Corbin & Strauss,

2008). Grounded theory is an approach which is characterized by systematic processes of collecting, coding, analysing and sub-dividing data into categories using the themes and sub-themes that emerge from the data itself (Corbin and Strauss, 1990; Corbin and Strauss, 2008). It is one of the most rigorous, popular and widely recognized approaches to qualitative research (Jeff and Taylor 2014). Using the grounded theory approach, the coding enabled division and sub-division of data into common themes and sub-themes embedded in the data.

The analytic notes for all the two methods were accomplished through the questioning of data and making comparisons as suggested by Corbin and Strauss (2008). The questioning of datainvolved exploring opinions expressed by interviewees and observations made by the researcher in order to determine the extent to which they addressed the aims and objectives of this study and confirmed or disconfirmed speculations that held by the researcher prior to the undertaking of this study.

Findings

Rodgers and Veil's (2008) pronouncement on the importance of language in interpersonal communication provided an insight into how diabetes health promoters could verbally and otherwise communicate diabetes health messages to remote villagers. Diabetes health promoters would have to adopt a persona that would enable them to interact with the villagers. One way to do this would be to use the language that rural area communities understood when communicating diabetes health messages to them. Given that many remote villagers were illiterate and could not speak English, the language spoken by campaign officials had to communicate their messages in Setswana. It is only through the use of the villagers' local languages and interaction with them that they (remote villagers) would be able to understand diabetes health messages and start attaching meanings to them.

This study discovered that notwithstanding the fact that diabetes health promoters used English for all their official communications and that some of them could not even speak Setswana (Setswana is the villagers' local language), Setswana was used to disseminate diabetes health messages both rhetorically and in print. Presentations were done mostly by villages' opinion leaders such as nurses with diabetes health promotion officials playing facilitation and advisory roles from the background as suggested by Ford and Yep (2003). Also, all the fliers and posters

in the medical centres were written in the villagers' common language. Using Setswana to communicate health information to the villagers was in synch with the villagers' discursive practices and was an indication that communities' socio-cultural orientations wereduly considered when the messages were designed and executed. This was again congruent with Rodgers and Veil's (2008)position that in most cases it is not the content or the subject matter that matters most in stimulating viewers' interest in the information presented to them; rather, it is the communicator's ability to prove membership of the community through the use of a local language. To this end, diabetes campaign information would only be viewed as credible if it was obtained through the voice, and in most cases, the language of the target community.

This study also uncovered that diabetes health promoters used non-verbal cues and behaviours that were commensurate with the cultural practices of remote villagers. Such include: dress, and use of communication strategies such as theatre, local dances and songs. In terms of dress, diabetes health promotion practitioners came to the campaigns wearing simple and casual clothes. At the clinics, nurses who presented during wellness talks wore their work uniforms. The way they dressed definitely had a huge impact on how their messages were received by remote rural area people. If they came to the campaigns wearing expensive suits and dresses, and driving flashy cars, the poor rural area communities might not identify with them and this would most likely result in them not taking their messages seriously. Also the use of theatre, local dances and songs to communicate diabetes messages, with diabetes health promoters keenly and joyfully taking part in them, made rural area communities identify with the messages. By joyfully verbally interacting, dancing and singing with the villagers as equals also made them (the villagers) identify with diabetes health practitioners. It can logically be concluded that if they used any other strategies which fall outside remote villagers' culture that would have resulted in their messages not taken seriously.

McDaniel's (2009) argument that inappropriate or misused nonverbal behaviours can lead to misunderstanding or fights had far reaching implications for diabetes promotion in the villages. It suggested that diabetes health promotion practitioners would have to learn and have a thorough understanding of non-verbal cues in remote rural area communities to avoid the occurrence of unpleasant situations during their campaigns. It was also crucial for them to recognize that the culture of remote rural area people directly influenced the use of, and meanings given to their

non-verbal cues. As a result, a misuse or inappropriate use of non-verbal behaviour by campaign officials, might be interpreted by the villagers as disrespect for their culture. To give an example: the way campaign officials dressed during the campaigns would have an impact on how their messages were received by rural area people.

The findings further showed that diabetes health promotion officials demonstrated a thorough knowledge and awareness of the cultural rules that govern the contexts of interpersonal communication in remote rural area settlements. They demonstrated this through the use and involvement of some influential members of the village communities (opinion leaders) to communicate diabetes health messages to their people while they (diabetes health promoters) were playing advisory roles from behind. These included local nurses, clergy men and women, villages' councillors and others. Other than making opinion leaders present diabetes messages during the campaigns/wellness talks, it also emerged during the interviews that communities were involved through representation evenat the planning stages.

Given that culture is constructed and communicated by its members, it was fitting for diabetes health promoters to communicatively involve remote villagers who had an understanding of the cultures, needs, aspirations and discursive and communicative processes of the villagers. It was evident that communicatively involving the villagers helped diabetes health promotion practitioners to develop audience-centred messages and materials that would appeal to remote villagers. For instance, the choice of communication strategies and venues took cognizance of the nature of the communities and their physical localities. Given that most of remote villagers were illiterate and mostly shared and acquired information through interpersonal means, face-to-face interpersonal communication strategies were used during the campaigns despite the fact that diabetes health promoters themselves mostly communicated in writing and through new media technologies. In terms of campaign venues,campaigns were held at the village Assembly areas (called kgotla in the local language) whereas wellness talks were held in the village clinics. The choice of a kgotla the hold the campaigns was commensurate with villagers' cultural practices as community meetings and events were always held at the kgotla.

The issue of contextual influences is very important in health campaigns. Based on how well social constructionism is adapted to diabetes campaigns in remote villages, the issue of context should pertain to all diabetes promoters' communication processes. Diabetes health promotion

officials therefore had to be aware of the cultural rules that govern the contexts of interpersonal communication in remote rural area settlements.

Conclusion

The findings above show thatin communicating diabetes health messages to the villagers, diabetes health promoters project the behaviours and communication processes that mask their real selves. While "inside" they are the educated social elites, "outside"they are like the villagers; speaking the villagers' local language, embracing and practising the villagers' non-verbal behaviours and adopting the villagers' contextual epithets to organize and run the campaigns. Put different, they adopt a dramaturgical approach and disguise their own real selves through developing and assuming a series of elaborate ruses to appear like the villagers and assume the villagers' cultural orientations. As the findings show, what emerged during the campaigns isa contrast between health promoters' appearances/ communication behaviours and reality. They are not what they appear to be as they traverse the terrain of diabetes health promotion in the life worlds of the villagers. In the words of D'Cruz (2014), they shift to a different "gear" as they move from their own life world into the villagers' life world. But it is important to note that, that cultivation of a different professional persona by diabetes health promoters is a necessary "deception" in that it facilitates the interaction between them and the villagers thereby enhancing the understanding and conceptualisation of diabetes health messages.

Practical Implications

The findings of this study reiterate that need to align the communication of health messages to the socio-cultural and communication practices of target audiences. It must be noted that the field of health promotion emphasizes using channels of communication that can reach target communities with health promotion messages. As Rodgers and Veil (2010) note, effective dissemination of health messages depends chiefly on a health promoter's awareness and use of communication channels that would reach everyone in target communities. As can be discerned from the discussion of the findings, if diabetes health promoters could have disseminated diabetes campaign messages from the ambit and assumptions of their own cultures and their relative and apparent expert and elitist positions as I speculated prior to this study, the poor and illiterate villagers could not have been reached by diabetes health messages. As Rodgers and

Veil (2010) posit, even health communication programmes that have been methodically planned may result in limited impact if some or entire membership of the target group are not reached by the messages.

References

Airhihenbuwa, C.O,(1995).*Health and Culture: Beyond the Western Paradigm*, Sage Publications, London.

D'Cruz, G. 2014,"Dakly Dreaming (in) Authenticity: The Self/Persona Opposition in Dexter", *M/C Journal-"Persona"*, 17 (3).

Dutta, M.(2008).*Communicating Health: A Culture-Centred Perspective*, Polity, Cambridge.

Elliot, A.(2014).*Concepts of the Self*, Polity Press, Cambridge.

Gill, G.V. et al. (2009), "A Sub Saharan African Perspective of Diabetes" *Diabetologia*, 52:pp 8-16.

Ford, L.A.& Yep, G.A.2003. "Working along the Margins: Developing Community-Based Strategies for Communicating about health with Marginalized Groups", in Thompson, TL Dorsey, AM Miller, KI & Parrot, R (eds), *Handbook of Health Communication*, Lawrence Erlbaum Associates, New Jersey.

Goffman, E.(1969). *The Presentation of Self in Everyday Life*, Pelican Books, London.

Hanemann, U. 2005. "*Literacy in Botswana: A Paper Prepared for the Education for all Global Monitoring Report 2006 Literacy for Life"*, Retrieved 17 August 2011, <http://unesdoc.unesco.org/images/0014/001460/46005e.

Hetherington, K.(1998).*Expressions of Identity: Space, Performance and Politics*, SAGE Publications, New Delhi.

Marshall, P.D 2014, "Seriality and Persona", *M/C Journal-"Persona",*17 (3).

Majelantle, A.(2011).*2011 Population and Housing Census Preliminary Results Brief*, Government Printers, Gaborone.

Norr, K.F., Tlou, S. and Matshediso, R.M.2004, "Impact of Peer Group Education on HIV Prevention among Women in Botswana", *Health Care for Women International*, 25:pp 210-226.

Moore, M. Johnson, S. and Blakeney, C.(2004).*Mental Health Promotion Feasibility Study*. Gladesville: Mental health Association NSW Inc.

Naidoo, J. and Wills J.(2011).*Developing Practice for Public Health and Health Promotion*: Edinburgh: Elsevier.

Sabone, M.B.2009, "The Promotion of Mental Health through Cultural Values, Institutions, and Practices: A Reflection on Some Aspects of Botswana Culture", *Issues in Mental Health Nursing*, No 30, pp 777-787.