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Assessing Health Communication Strategies to Reduce Maternal and Child Mortality in Rural Hargeisa: Insights from Hargeisa Group Hospital

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Abstract

Despite national and global efforts, maternal and child mortality remains a pressing public health emergency in Somaliland, particularly in underserved rural populations. This study examines the health communication approaches implemented by Hargeisa Group Hospital, the main public referral hospital in Somaliland to reduce mother and child mortality with special emphasis on rural areas surrounding the city of Hargeisa. The research was informed by Somaliland's National Social and Behavior Change Strategy (2024–2026) and the National Health Policy. The study applies a qualitative approach with thematic network analysis with data acquired through in-depth interviews, focus group discussions and document review with hospital staff, Ministry of Health officials and community members. Results show that Hargeisa Group Hospital implements a multi-pronged approach that includes a specialized Social and Behavior Change (SBC), community health workers, traditional birth attendants, Somali language materials, radio messages, and mother-to-mother support groups. At the institutional level, the hospital has initiated free maternal services, pre-emergency response systems and specialized ambulances. But the analysis points to a crucial gap between institutional planning and community-level realities. Communication methods function mostly in a top-down, monological manner that promotes information transmission over real discussion and engagement. Thus, rural women are systematically excluded from health messages that are consistent, understandable and culturally relevant. Existing impediments include episodic communication, over-reliance on inaccessible digital platforms, use of medical jargon, limited rural outreach, and poor integration of traditional birth attendants and elders. As a result, this study proposes the term "rural neglect" to characterize the persistent failure to achieve equitable implementation of national SBC goals at the local level. The findings argue that addressing sustained rates of maternal and child mortality requires a fundamental recalibration toward horizontal and participatory communication models that co-create health messages with communities. Several recommendations are proposed including strengthening community participation, building health professionals' capacity in interpersonal communication, prioritizing radio and in-person outreach and formalizing community feedback mechanisms. These findings contribute to development communication discourse in fragile and under-resourced health systems.

Keywords: health communication, maternal mortality, child health, participative communication, Somaliland, rural health, Hargeisa Group Hospital

Introduction

Sub-Saharan Africa has the highest maternal and child mortality globally (WHO, 2025). There has been a 45% reduction in maternal mortality since 1990, but the progress in achieving Sustainable Development Goal 3, which aims to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030, has been slow (Bohren et al., 2015). In 2015, there were around 303,000 maternal deaths, with sub-Saharan Africa and Asia accounting for the majority of these deaths (Moran et al., 2016). In response to this drop, the Sustainable Development Goals have been set up as a continuation with the aim of reducing the global maternal mortality ratio. In various regions across the African and Asian continents, strategies of health communication and

community-based interventions have been recommended to improve maternal health outcomes. (Malikhao, 2020). Furthermore, in recognition of the critical importance of addressing poverty and development challenges in order to achieve lasting peace and security, the United Nations introduced time-bound objectives called the "Millennium Development Goals", which were supported by specific objectives and indicators to measure progress. Goal number eight, "Developing a Global Partnership for Development" was especially important as it pointed to the need for joint efforts between developed and developing countries (Jolly, 2004). To respond to this situation, effective health communication initiatives are needed. Access to and utilization of quality prenatal care is an effective health communication strategy in reducing maternal and child mortality as it avails an opportunity for early identification and management of pregnancy-related complications that could otherwise prove fatal (Amo-Adjei & Tuoyire, 2016; Jolivet et al., 2018; Kumari et al., 2023; Tsegaw et al., 2023).

Health communication refers to the strategic use of communication methods to inform, educate and influence health-related decisions and behaviors. In maternal and child mortality, communication strategies such as community outreach, radio programs, phone messages and interpersonal communication are used to raise awareness and inspire the operation of antenatal, delivery, and postnatal care services. Signs from several African countries demonstrate that effective health communication can increase maternal health outcomes by increasing health-seeking behavior and promoting primary access to services (Gupta D et al., 2021).

Despite these efforts, maternal mortality rates are unacceptably high in many poor countries, especially in sub-Saharan Africa, and women face severe impediments to excellent health care services. There has been a 44% drop in maternal fatalities between 1990 and 2015, however, the pace of progress has been uneven and some countries are falling behind. Extensive research into the factors behind these poor maternal health outcomes in low-resource settings has highlighted the complex interplay of social, economic and systemic barriers that prevent women from receiving the care they need (Lori & Starke, 2011; Jolivet et al., 2018). The development of health communication techniques to address these obstacles is thus critical to improving mother and child health outcomes.

It is important to note that women with mistimed or undesired pregnancies were less likely to obtain proper prenatal care, which may increase their risk for negative health outcomes (Amo-Adjei & Tuoyire, 2016). For this reason, effective health communication can spread awareness of antenatal care (ANC), encourage healthy behaviors, and support women to seek skilled healthcare during pregnancy and childbirth. These initiatives comprise a broad set of activities to inform, educate and empower mothers and families on maternal health, nutrition and access to health care. Some of the ways to improve health literacy are awareness campaigns, training of community health workers and mobilization of resources, which eventually leads to better healthcare-seeking behaviors and improved maternal and child health outcomes (Amo-Adjei & Tuoyire, 2016; Ruas et al., 2020).

Health communication is defined as the art and science of informing, influencing and motivating individual and community decisions to develop health care and health policy (Kreps and Neuhauser 2015). Health-related mass media campaigns are organized and purposive efforts to communicate to, persuade and influence a population to consider, adopt or change to more health-enhancing practices. Health communication messages are essential for promoting behavior change

among individuals and groups. If successfully produced, they can increase knowledge and awareness of health complications, influence perceptions which may lead to behavior change, increase demand for health services, and inform decision-making. In Cameroon, the media have been seen as having tremendous potential to promote reproductive healthcare, especially in rural communities. As Ngange and Ndode (2023) explain, media messages for rural communities are packaged and delivered through different communication channels and methodologies to reach target groups. The ultimate goal of such messages is to achieve behavior change through communication in areas related to birth control and healthy living. In the African context, the realities are that numerous countries experience high maternal and child death rates. These rates are compounded by socioeconomic problems, poor healthcare infrastructure, and cultural barriers to health practices. For example, in sub-Saharan Africa, research indicates that women who had unwanted pregnancies were less likely to use prenatal health services, increasing their risk of bad outcomes (Okedo-Alex et al., 2019). Therefore, poor access to appropriate prenatal care has also been cited as a major cause of preventable maternal deaths in the region.

In the Horn of Africa, maternal and child mortality remains a major public health challenge, particularly in fragile and resource-constrained situations (WHO,2025). Health communication initiatives that tackle these issues can significantly boost mother and child health outcomes, supporting the wider global effort to minimize unnecessary deaths. For example, in Uganda, the rates of maternal and child mortality are still dangerously high. Maternal and child mortality was estimated at 189 deaths per 100,000 live births in 2022 and the under-five mortality rate at 22 deaths per 1,000 live births. Socio-economic factors including poverty, inequality and restricted access to effective health care services are the main drivers of these alarming health outcomes in the country (Turigye B., et al 2025). From Ethiopia's front, its health demographic census indicates that maternal and child mortality rates are still among the highest globally with 412 maternal deaths per 100,000 live births and 30 neonatal deaths per 1,000 live births. Despite significant progress in reducing under-five mortality in the last three decades, achievement in reducing neonatal deaths has been limited in Ethiopia (Tesfau et al., 2022). Somalia, which is a country ravaged by civil wars, famines, and facing among other challenges, also has one of the worst maternal and child health situations in the world. In Somalia, the maternal mortality ratio is 692 maternal deaths per 100,000 live births. For example, 4 out of 100 children in Somalia die in the first month of life, 8 out of 100 before they reach their first birthday, and 1 out of 8 do not live until the age of five (Mohamed et al, 2021).

Within this regional content, Somaliland has aimed to improve maternal and child health outcomes and strengthen its health system and policy framework. Somaliland developed its sectoral development strategies through the National Development Plan III (2023-2027). This NDP III contributes to Somaliland's long-term goal and to sustaining quick and broad-based Somaliland economic growth and experience with implementing development policies. The promotion of community ownership and empowerment through successful social mobilization and persistent awareness activities is a major component of the country's NDP III health sector development plan. The plan serves as a key mechanism for prevention, health promotion, behavioral change communication and basic curative care through the effective implementation of health communication initiatives. Among these efforts, particular focus is placed on lowering mother and child mortality (National Health Policy III. n.d). Despite global and national efforts to enhance women's health, maternal mortality continues to be an unaddressed problem in many underdeveloped nations including Somaliland. Therefore, Somaliland still has one of the highest

mortality rates in the world. The current estimates of maternal and child mortality are 396 deaths per 100,000 live births (Egal et al, 2023).

In rural areas surrounding Hargeisa, maternal and infant mortality continues to be a major public health problem. This problem still remains despite several health interventions that try to improve mother and child health outcomes. Health communication is an important component of this challenge, as it involves tactics for informing and motivating people and communities about critical health issues. However, the impact of these communication efforts has not been fully evaluated resulting in gaps in awareness and poor health seeking behaviors among the afflicted communities (Somaliland Health and Demographic Survey 2020).

The Hargeisa Group Hospital (HGH) is the cornerstone of healthcare in Somaliland and started its journey in 1953 as the first governmental referral hospital in Hargeisa, the capital city of Somaliland. The HGH was doing roughly 5,500 deliveries a year in 2013, but has serious problems in neonatal care, because of poor resources and services (Lundeby et al., 2020, p. 2). The hospital has many health communication initiatives to overcome the difficulties of maternal and child mortality. One of the most effective ways is to provide local nurses and doctors with extensive training programs on WHO plans. Somaliland's Ministry of Health Development is the lead institution responsible for implementing these strategies at national level. Within this health system, Hargeisa Group Hospital plays a significant role as the main referral hospital in Somaliland, receiving maternal and child health cases both from urban and rural areas. The HGH also provides maternal education on breastfeeding, as about half of the mothers received instruction while in the hospital (Lundeby et al., 2020, p. 4). Therefore, this hospital was selected as the study site given its position as the country's largest referral hospital and its direct patient pipeline from rural communities, making it a relevant access point for examining how health communication strategies reach or fail to reach rural populations.

An efficient health communication plan is vital because it gives the public the knowledge and resources they need to respond successfully to health emergencies such as flu epidemics and maternal and newborn deaths. The latest figures from the Ministry of Health in Somaliland show that maternal and child mortality rates remain unacceptably high, with a huge difference in access to healthcare between urban and rural areas (Somaliland Health Ministry, 2022). Although advancements have been made in the delivery of health services, progress is nevertheless hampered by harmful cultural norms and socio-economic hurdles. Women in these communities confront obstacles such as inadequate access to reproductive health care, lack of family planning resources, and prevalence of dangerous traditional practices, all of which contribute to high mother and child death rates.

The integration of ICTs in healthcare education, especially in rural areas, presents both opportunities and challenges. Mobile technology, when effectively utilized, can empower expectant mothers by providing timely reminders, extending services to underserved areas, and improving health outcomes. Advocacy for reaching villages with necessary information aligns with the potential of ICTs to bridge information gaps in rural communities (Ngange & Ndode, 2023). Therefore, it is vital to consider how health communication tactics might be tailored to engage with the distinct cultural and socioeconomic contexts of rural areas in order to effectively address these concerns. New data from the Somaliland Ministry of Health shows that maternal and child mortality rates are still shockingly high, and urban and rural access to healthcare is vastly different.

The study therefore, examines health communication tactics used to minimize mother and child mortality in rural areas. It focuses on whether these strategies successfully engage the rural people of Hargeisa Group Hospital and increase their awareness.

Health Communication Strategies at Hargeisa Group Hospital

Information is a fundamental resource for development, but even when the necessary information is available, not everyone benefits from it. There are sectors in society that are better informed than others. This disparity is more visible in developing countries. In these countries, a majority of the people live in rural areas, and are often left out of the existing information flow. Connecting rural communities to the global network is made possible with ICTs. When carefully designed and implemented, ICTs can establish a network for preserving, ordering, and transmitting information to rural communities (Ngange & Ndode, 2023). But providing infrastructure, hardware, and software alone is not sufficient. In order to empower individuals, they must be equipped with the necessary skills. Information in rural communities is largely hidden and not much has been discovered by researchers. It is also not surprising that some rural communities of the developing world are not fully aware of the existence and benefits of ICTs. So, it is imperative for ICTs to be introduced and exploited (especially by women of child bearing) in these communities.

The Hargeisa Group Hospital is the largest and the major referral hospital in Somaliland established during colonial era. This study is an analysis of the health communication strategies of HGH in Somaliland, in the context of reducing maternal and child mortality. It has three main objectives: to review the strategies applied; to assess their effectiveness; and to evaluate their impact on the target population. This report indicates that HGH has taken a multi-pronged strategy, mainly guided by the national Integrated Social and Behavior Change (SBC) Strategy (2022-2026). Key strategies included community outreach through using community health workers (CHWs) and traditional birth attendants (TBAs) to reach the grassroots, translating health materials into the Somali language, and employing multiple communication channels such as radio, television, social media and mobile-based reminders. Institutional measures such as a pre-emergency response system, free mother and child health services, and ambulances for the impoverished are in place to address economic and logistical hurdles to care. These initiatives conform to worldwide best practices from WHO and UNICEF, indicating a holistic, if unevenly applied, institutional commitment.

The main theoretical contribution of the study is the tension and potential synergy between two models of communication: the horizontal (two-way, participatory) model and the monological (one-way, top down) model. Quoting scholars like Obregon and Waisbord, the analysis contends that the horizontal model, which emphasizes dialogue, mutual feedback and community co-creation, is key to building trust, ownership, and sustainable behavioral change, especially with long-term issues like family planning and nutrition. The monological paradigm, however, is well suited for fast distribution of information in emergencies or large immunization efforts. This report demonstrates that although the theoretical basis for HGH's SBC strategy supports a mixed approach, its practical implementation leans towards a top-down, monological model. This is reflected in community comments indicating a tendency for messages to be delivered without substantial previous involvement which leads to low message penetration, mistrust and behavioral resistance, particularly in rural areas. The study indicates that while institutionalizing horizontal communication strategies such as community consultations and

participatory planning is crucial for long-term health behavior reform, these practices are neglected at present.

There is a major difference in the efficiency of certain communication tactics between urban and rural populations. Midwives and CHWs' interpersonal communication (IPC) is described as very successful since it facilitates direct coaching, trust building and immediate feedback. As one of the senior midwives stated during an in-depth interview "effective communication leads to understanding, trust and action" (Senior Midwife, HGH). Also, group communication methods, such as mother-to-mother support groups and engagement with community elders and local leaders, have proved successful in urban and peri-urban settings. However, the study results indicate mass media practices, particularly social media, are not aligned with the requirements and access patterns of rural and elderly communities. Radio was consistently identified by respondents as the most accessible medium for them. Yet, respondents also thought that messages were not properly customized for pregnant women or the reality of rural life. In addition, the use of medical jargon in health messaging was extensively condemned as a barrier to understanding and a violation of the SBC principle of culturally appropriate, audience-specific content. Discussion with HGH staff shared that messages use culturally specific Somali terms, but focus group participants showed that translations do not sufficiently clarify challenging medical ideas for communities' audiences.

One of the most important findings of this study highlighted the significant neglect of rural populations in health communication efforts. Focus group discussions and interviews regularly show that rural women receive very little, if any, structured maternal health messages from the hospital. As one rural responder said, "Most of the time we do not receive messages from the hospital about maternal and child health." Communication is generally episodic, and tends to happen mainly during national health campaigns or emergencies, rather than as a continuous, community-based strategy. This inconsistency in information only continues to foster low levels of awareness, misconceptions about prenatal care, and a reactive (as opposed to proactive) health-seeking behavior—where women only see a doctor when they are about to give birth or when there is an emergency. This is known as structural exclusion and opposes the main purpose of the SBC strategy to "leave no one behind." This suggests a gap between the national policy goals and the local level execution. Logistical hurdles, including poor infrastructure, lack of transit and inadequate funding for outreach activities, further exacerbate this rural-urban imbalance.

Another important finding is the cultural reliance on traditional knowledge and home deliveries that affects mother health outcomes. The study finds that many women in rural Hargeisa seek advice from elders, other women and traditional birth attendants (TBAs) instead of obtaining expert medical care. There is still a strong prevalence of myths and superstition regarding deliveries in the hospital, leading to high maternal and newborn mortality due to preventable complications. The hospital's strategy mentions working with TBAs and community elders, but the data indicate that this partnership is insufficiently structured or scaled. Traditional leaders were cited as important influencers for behavioral change, and bypassing them can lead to disinformation and opposition to contemporary healthcare. Interventions that are needed but not yet well developed include the official integration of TBAs into maternal health care systems, for example, training them as health communicators.

Furthermore, and very importantly, community perception data consistently identify three key barriers: lack of awareness and access; inefficient message delivery; and medium-audience mismatch. Most said health information was not part of a continuous discourse, but was shared occasionally. "The absence of 'regular updates' is damaging the credibility and continuity of the campaign." Participants also commented that messages received are often too infrequent or in inaccessible language. Without a doubt, social media platforms can have beneficial effects on people's health through conveying useful information related to health by various approaches, such as educational campaigns, series programs, and advertisements. Given the widespread influence of social media, well-designed social media campaigns can have beneficial effects not only on health knowledge and attitudes, but also on health behavior, with a potentially huge public health impact. However, there was much criticism of the overreliance on digital platforms like Facebook, since many women of reproductive age in rural areas do not use social media. Participants expressly asked for a return to radio based programs, community gatherings and direct engagement by health workers through house-to-house visits. The use of interpersonal and community-based techniques has been relatively underutilized, which is an opportunity squandered, given these are the most successful strategies for behavior change in low-literacy and low-media-penetration situations as widely documented.

Ultimately, the report concludes that while the Hargeisa Group Hospital has made commendable efforts in implementing diverse and innovative communication strategies, including free services, mobile clinics, and Somali-language materials, significant gaps in consistency, community engagement and rural outreach severely limit the overall effectiveness of their strategies in reducing maternal and child mortality. The most successful interventions have been participatory in model and community-based in delivery, but these are not the norm today. The main gap is the disconnect between national SBC goals and how they are translated to the local level, which creates what the study describes as "rural neglect." For health communication to be meaningful, it needs to be consistent, community-led, culturally relevant, and backed by systemic improvements in access to health care. However, future studies should include comparative studies between urban and rural areas, longitudinal studies to assess the impact of SBC programs and the use of mobile health technologies in resource-limited situations.

Recalibrating Health Communication

Women, like men, are pillars of development in society. Their wellbeing, and that of their child(ren) is a powerful indicator for peace, development, and stability in the family, community, and society. Over the years, mass media and communication have maintained a powerful effect on healthcare education in general and adolescent health in particular. The media have been instrumental channels in informing and educating women of child-bearing age on specific issues to aid them easily solve pre- and post-natal complications (Ngange & Ndode, 2023). Mass media refer to channels of mass communication such as newspapers, magazines, radio, television, Internet, and various social media platforms. Public health officials in Cameroon for example, depend a lot on these channels to raise awareness about healthcare challenges in both rural and urban areas in the country. Women of child-bearing age, for instance, face several challenges relating to birth, including child mortality (Ibid). So, for such messages to be effective, a need exists for a well-defined behavior change communication plan with the media actively involved at every stage. Key amongst the stages is formation of healthcare messages, coordination, evaluation and monitoring of the media campaign.

This study revealed deep-rooted "rural neglect", which Hargeisa Group Hospital must radically redress by reorienting its health communication approach from a top-down, monological model to a horizontal, participative framework. The hospital needs to institutionalize community engagement by having formal advisory boards of community health workers (CHWs), traditional birth attendants (TBAs), religious leaders and elders who co-create messaging at the beginning of the campaign. The process not only translates health messages into the Somali language but also embeds them culturally, using local analogies, proverbs and storytelling that are meaningful to rural populations. Second, communication methods have to be adapted to the realities of the audience: radio should be the main mass media, supported by loudspeaker announcements at markets and mosques, community meetings and house-to-house visits by CHWs. "Digital platforms like Facebook are useful for urban youth but should not be given priority in rural outreach." Third, the hospital needs to move from episodic advertising to ongoing communication throughout the year.

Furthermore, regular weekly radio spots, monthly community talks and ongoing person-to-person interaction will establish trust and guarantee that maternal health messages are not only heard but also internalized. All additional resources should be updated for low-literacy audiences with visual aids, infographics and audio messaging and avoiding medical jargon to properly coordinate these activities. Finally, formalized feedback mechanisms, like mobile-based surveys, call-in radio shows and suggestion boxes at health posts, should be in place to allow for two-way contact and enable communities to raise issues, ask questions, and shape ongoing initiatives. But without these structural changes, tactics, well-intentioned or not, will continue to miss their most susceptible populations.

In addition to communication-specific adjustments, structural improvements in access to health care and workforce capability are needed. HGH should expand mobile clinic services and outreach activities to rural and remote areas across Somaliland, combining health communication with service delivery so that women get information and care at the same time. CHW and midwife training programs should be broadened to include advanced interpersonal communication (IPC) and behavioral modification approaches, with a focus on empathic listening, negotiation skills, and culturally sensitive counseling. TBAs, trusted in rural communities, need to be legally incorporated as paid or incentivized health communicators into the maternal health system with training on danger sign recognition, promotion of competent birth attendance and referral of women to facilities.

At the same time, the hospital must engage with Somaliland's Ministry of Health Development, NGOs and academic institutions to create a uniform, community-based health communication curriculum for rural outreach workers. Infrastructural impediments to healthcare, such as bad roads, shortage of transport and limited fuel for ambulances, need focused investment and public-private partnerships. The pre-emergency response system and dedicated ambulances for the needy are good but need to be scaled out to reach remote districts with clear referral paths and communication standards. Additionally, the hospital should build a community feedback loop wherein findings from study directly impact quarterly strategy changes, making interventions sensitive to developing needs. More importantly, longitudinal impact assessments should be conducted to measure changes over time in awareness, health-seeking behavior and mortality markers. To reduce maternal and child mortality in rural Somaliland in the end, there is no need for more communication, but better, fairer, and really participative communication in a strengthened

health system that prioritizes equity, cultural appropriateness and continuous community collaboration.

Conclusion

This study identifies that although Hargeisa Group Hospital has made commendable and multifaceted efforts to reduce maternal and child mortality through health communication, these efforts are challenged by a profound disconnect between institutional planning and community realities especially in rural Hargeisa. The hospital's acceptance of the National Social and Behavior Change Strategy, deployment of community health workers, translation of materials into Somali, and delivery of free maternal services are indicative of a real institutional commitment. However, the results clearly illustrate that these interventions mostly function in a top-down and monological style of communication that highlights the transmission of information instead of real discussion and community involvement.

Thus, rural women, the most vulnerable population and marginalized, remain systematically excluded from health messaging that is consistent, understandable and culturally resonant. The episodic nature of communication, dependence on inaccessible digital platforms, use of medical jargon and lack of continuous outreach have contributed to poor awareness, misconceptions about prenatal care and reactionary health-seeking behaviors. In addition, the use of traditional delivery attendants and guidance from elders remains culturally entrenched, and without formally incorporating these agents into the communication framework, continues to contribute to unnecessary difficulties and home births. As a result, the study shows that even well-resourced tactics will not bring about durable behavioral change or significantly reduce death rates unless horizontal, participatory communication models that co-create messages from the start with communities are institutionalized.

This study importantly identifies what might be called "rural neglect" in the health communication architecture of Somaliland – a systematic inability to adapt national SBC objectives into localized and equitable execution. Mother-to-mother support groups, radio campaigns, and interpersonal connection with midwives are available to urban and peri-urban populations, but rural areas lack or have very little structured health information and depend on informal networks and traditional knowledge. This gap is contrary to the promise of the SBC strategy to "leave no one behind" and hinders Somaliland's progress toward Sustainable Development Goal 3. The study also finds that effective health communication cannot be an addition to professional services but must be an integrated, continuous and community-driven activity. Successful interventions – such as those involving community elders, mother-to-mother groups and interpersonal communication by trained midwives – share a number of traits. They are dialogic, trust-based and culturally ingrained.

The path forward thus requires a fundamental recalibration: from episodic campaigns to sustained community engagement; from digital-first approaches to radio and in-person outreach; from top-down messaging to participatory co-creation; and from hospital-centric delivery to mobile and community-based models. Unless physical constraints are addressed, community health workers and traditional birth attendants are trained as empowered communicators and feedback mechanisms are formalized, health communication in Hargeisa will continue to

perpetuate inequality. Ultimately, what is needed to reduce mother and child mortality in rural Somaliland is not more communication, but better, fairer and really participative communication.

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