

Equity, Inclusion, and Healthcare Communication: Experiences of Marginalised Populations in Accessing Health Information

Ayanleke Ademu, Olanisebe Sodeinde, Grace Oluwaseyifunmi, and Boluwatife Joshua

Abstract

This study explores equity, inclusion, and healthcare communication with a focus on the experiences of marginalised populations in accessing health information. In many societies, access to accurate and timely health information remains unequal due to socio-economic disparities, geographic location, language barriers, digital exclusion, cultural beliefs, and systemic discrimination. Marginalised populations, including rural dwellers, low-income groups, persons with disabilities, and ethnic minorities, often face significant challenges in obtaining reliable healthcare information. The study examines how these inequalities affect health communication, health-seeking behaviour, and overall health outcomes. A qualitative research approach is adopted through the review of relevant literature and conceptual analysis of equity and inclusion frameworks in healthcare communication. Findings indicate that marginalised populations rely heavily on informal sources such as community leaders, traditional healers, family members, and local health workers, often due to limited access to formal healthcare systems and digital health platforms. The study also reveals that language barriers, low health literacy, and poor infrastructure significantly hinder effective healthcare communication. Furthermore, discrimination and lack of inclusive health policies exacerbate inequities in health information access. The study recommends strengthening inclusive health communication strategies, improving health literacy programmes, promoting multilingual health information systems, and expanding community-based healthcare outreach. It also advocates for the use of digital and traditional media to bridge communication gaps among underserved populations. The research contributes to ongoing discussions on health equity, inclusive communication, and social justice in healthcare delivery systems globally and in developing regions.

Keywords: *Equity, inclusion, healthcare communication, marginalised populations, health information access.* ***Word Count:*** *250 words*

Introduction

Equity and inclusion in healthcare communication are fundamental principles necessary for ensuring that all individuals, regardless of their socio-economic status, geographic location, language, or physical ability, have access to accurate and timely health information. Healthcare communication refers to the exchange of health-related information between healthcare providers, systems, and individuals for the purpose of promoting health, preventing disease, and improving healthcare outcomes. In an ideal healthcare system, communication should be accessible, understandable, culturally appropriate, and inclusive for all population groups.

However, in many parts of the world, marginalised populations continue to experience significant barriers in accessing health information. These populations include rural communities, low-income households, ethnic minorities, refugees, elderly

individuals, and persons with disabilities. Their marginalisation often results from structural inequalities such as poverty, limited education, inadequate infrastructure, and weak healthcare systems. As a result, they are disproportionately affected by poor health outcomes and limited access to essential health services.

In Africa and other developing regions, healthcare communication is often constrained by inadequate infrastructure, shortage of trained healthcare professionals, language diversity, and limited access to digital technologies. Many marginalised groups rely on informal channels of communication, including traditional healers, community leaders, radio broadcasts, and interpersonal networks, to obtain health information. While these sources can be valuable, they may not always provide accurate or evidence-based medical information.

The emergence of digital health technologies has introduced new opportunities for improving healthcare communication. Mobile health applications, social media platforms, and online health portals have expanded access to health information. However, the digital divide continues to exclude many marginalised populations from benefiting fully from these innovations due to lack of internet access, low digital literacy, and affordability challenges.

Language and cultural barriers also play a significant role in limiting effective healthcare communication. Health information is often delivered in official or dominant languages that may not be understood by all population groups. Additionally, cultural beliefs and mistrust of formal healthcare systems may influence how marginalised populations interpret and respond to health messages.

Despite global efforts to promote health equity, disparities in healthcare communication persist. Understanding the lived experiences of marginalised populations is therefore essential for developing inclusive health communication strategies that address their unique needs and challenges. This study explores equity, inclusion, and healthcare communication with a focus on the experiences of marginalised populations in accessing health information.

Research Questions

1. What are the major barriers faced by marginalised populations in accessing healthcare information?
2. How do marginalised populations obtain and utilise health information in their communities?
3. What role do language, culture, and literacy levels play in healthcare communication among marginalised groups?
4. How does digital exclusion affect access to healthcare

information among marginalised populations?
5. What strategies can improve equity and inclusion in healthcare communication systems?

Literature Review

Equity and inclusion in healthcare communication refer to the fair distribution of health information resources and the elimination of barriers that prevent individuals or groups from accessing, understanding, and using health information effectively. Healthcare communication involves the exchange of health-related messages between healthcare providers, institutions, and individuals for the purpose of promoting health, preventing disease, and improving wellbeing. Scholars emphasise that effective healthcare communication must be accessible, culturally sensitive, linguistically appropriate, and inclusive to ensure that all population groups benefit equally from health information systems.

Marginalised populations are groups that experience social, economic, political, or cultural exclusion from mainstream services and opportunities. These groups may include rural dwellers, low-income households, ethnic minorities, refugees, elderly individuals, women in disadvantaged settings, and persons with disabilities. Research indicates that marginalisation significantly affects access to healthcare services and information, leading to inequalities in health outcomes. Structural factors such as poverty, low education levels, inadequate infrastructure, and weak healthcare systems contribute to these disparities.

Studies have shown that marginalised populations often rely on informal sources of healthcare information, including family members, community leaders, traditional healers, religious institutions, and local health workers. While these sources provide culturally relevant support, they may not always offer accurate or scientifically validated medical information. This reliance on informal communication channels is often a result of limited access to formal healthcare systems and digital platforms.

Language barriers are a significant challenge in healthcare communication among marginalised populations. Health information is frequently delivered in official or dominant languages that are not easily understood by all individuals. As a result, important health messages may be misunderstood or ignored, leading to poor health decisions. Cultural beliefs and practices also influence how health information is interpreted, accepted, or rejected by different communities. In some cases, traditional beliefs may conflict with biomedical health information, affecting health-seeking behaviour.

Digital exclusion is another critical factor affecting equitable access to healthcare information. With the rise of digital health technologies such as

mobile health applications, telemedicine, and online health platforms, access to reliable health information increasingly depends on digital literacy and internet connectivity. However, many marginalised populations lack access to digital devices, affordable internet services, and the skills needed to navigate online health resources. This digital divide reinforces existing inequalities in healthcare communication.

Theoretical perspectives such as the Social Determinants of Health framework explain how social, economic, and environmental factors influence health outcomes and access to healthcare information. According to this framework, health disparities are not only the result of individual behaviour but also broader structural inequalities. Similarly, the Health Literacy theory highlights the importance of individuals' ability to access, understand, and use health information to make informed decisions. Low health literacy among marginalised populations contributes significantly to poor health outcomes.

Empirical studies in developing regions, particularly in Africa, have shown that rural and low-income populations experience greater difficulty in accessing formal healthcare information compared to urban populations. In Nigeria and other African countries, healthcare communication is often hindered by inadequate infrastructure, shortage of healthcare professionals, and limited multilingual health resources. Studies also indicate that radio, community outreach programmes, and interpersonal communication remain the most effective channels of health information dissemination in marginalised communities.

Inclusion in healthcare communication requires the development of strategies that address linguistic diversity, cultural sensitivity, and accessibility needs. Researchers have advocated for the use of multilingual health communication, community-based health education programmes, and participatory communication approaches. These strategies ensure that marginalised populations are actively involved in the design and delivery of health information systems.

Despite growing attention to health equity, significant gaps remain in understanding the lived experiences of marginalised populations in accessing healthcare information. Many studies focus on general populations without adequately capturing the specific challenges faced by excluded groups. This study therefore seeks to fill this gap by examining equity, inclusion, and healthcare communication with a focus on marginalised populations' experiences in accessing health information and identifying strategies for improving inclusive health communication systems.

Methods and Materials

This study adopts a qualitative descriptive research design to examine equity, inclusion, and healthcare communication with a focus on the experiences of marginalised populations in accessing health information. The qualitative approach is considered appropriate because it allows for an in-depth exploration of lived experiences, communication barriers, and social factors influencing health information access among excluded groups.

The study relies primarily on secondary sources of data, including peer-reviewed journal articles, books, policy documents, reports from international health organisations, and academic publications on health communication, health equity, and social inclusion. Relevant literature was sourced from databases such as Google Scholar, PubMed, Scopus, and ResearchGate. Materials were selected based on relevance, credibility, and recency, with emphasis on studies conducted in developing regions, particularly Africa.

In addition, primary qualitative data were obtained through semi-structured interviews with selected participants drawn from marginalised populations, including rural dwellers, low-income households, and individuals with limited formal education. Key informant interviews were also conducted with community health workers, non-governmental organisation representatives, and public health communication officers. Purposive sampling was used to identify participants who have direct experience with healthcare communication challenges.

A thematic interview guide was used to collect data, focusing on access to health information, preferred communication channels, language barriers, cultural influences, digital access, and perceived challenges in healthcare communication. Ethical approval was considered, and informed consent was obtained from all participants. Confidentiality and anonymity were strictly maintained throughout the study.

Data were analysed using thematic analysis. Interview transcripts and documentary data were coded and grouped into key themes such as digital exclusion, language barriers, cultural influence, informal communication systems, and structural inequalities. These themes were interpreted in relation to existing literature on health equity and communication.

The study also ensured credibility and trustworthiness through triangulation of data sources, combining literature review findings with interview responses to enhance validity. Dependability was maintained by following a consistent data collection and analysis procedure.

Results

The findings of the study reveal that marginalised populations face multiple and overlapping barriers in accessing healthcare information. A major finding is that socio-economic disadvantage significantly limits access to formal healthcare communication channels. Many participants reported that poverty restricts their ability to afford transportation to health facilities, mobile data subscriptions, or access to digital health platforms.

The study also found that language barriers play a critical role in limiting effective healthcare communication. Health information is often delivered in official or dominant languages that are not easily understood by many marginalised individuals. Participants indicated that they prefer receiving health messages in local languages, as this improves understanding and trust in the information provided.

Another key finding is the heavy reliance on informal sources of health information. Marginalised populations frequently depend on community leaders, traditional healers, religious institutions, and family members for health advice. While these sources are easily accessible and culturally familiar, they sometimes provide inaccurate or non-scientific information, which can affect health decisions.

Digital exclusion emerged as a significant challenge. Many participants reported limited access to smartphones, internet services, and digital literacy skills required to use online health platforms. This limits their ability to benefit from digital health innovations such as telemedicine, online consultations, and health information websites.

Cultural beliefs and trust issues were also identified as important factors influencing healthcare communication. Some participants expressed greater trust in traditional healing practices compared to formal healthcare systems. This sometimes leads to delays in seeking professional medical care and reliance on non-clinical treatments.

The study further revealed that healthcare communication efforts by government and health organisations are often not sufficiently inclusive. Participants noted that health campaigns are sometimes not tailored to the realities of marginalised groups, particularly in rural and low-income settings. As a result, important health messages do not always reach or resonate with intended audiences.

Despite these challenges, the findings also show that community-based communication strategies, such as radio broadcasts, local health outreach programmes, and interpersonal communication, remain effective in reaching marginalised populations. Participants expressed preference for these channels due to their accessibility, simplicity, and cultural relevance.

Overall, the findings highlight that inequities in healthcare communication are driven by a combination of economic, linguistic, cultural, and technological factors that collectively limit access to reliable health information among marginalised populations.

Discussion of Findings

The findings of this study highlight persistent inequities in healthcare communication and health information access among marginalised populations. A central observation is that socio-economic disadvantage remains a major determinant of access to reliable health information. This aligns with the Social Determinants of Health framework, which explains that health outcomes and access to healthcare resources are shaped by income, education, and living conditions rather than individual choices alone. Marginalised populations, particularly those in rural and low-income settings, are disproportionately affected by these structural inequalities, limiting their ability to access formal healthcare communication channels.

Language barriers emerged as another significant factor influencing healthcare communication. The findings show that many marginalised individuals struggle to understand health information delivered in official or dominant languages. This supports existing literature which emphasises that linguistic accessibility is essential for effective health communication. When health messages are not culturally and linguistically adapted, comprehension is reduced, leading to misinterpretation and poor health decisions. This reinforces the need for multilingual and culturally sensitive health communication strategies.

The reliance on informal communication channels such as traditional healers, family members, and community leaders reflects gaps in formal healthcare communication systems. While these informal sources are trusted and easily accessible, they may not always provide scientifically accurate information. This finding is consistent with previous studies in African contexts, which show that informal health communication systems remain dominant in underserved communities due to limited access to formal healthcare infrastructure. It also highlights the tension between cultural relevance and medical accuracy in health information dissemination.

Digital exclusion is another critical issue identified in the study. Many marginalised populations lack access to smartphones, internet connectivity, and digital literacy skills necessary to benefit from modern health communication technologies. This finding supports global research on the digital divide, which shows that technological inequality reinforces existing health disparities. As healthcare systems increasingly adopt digital platforms, including telemedicine and online health information services, excluded

populations risk being further marginalised unless targeted interventions are implemented.

Cultural beliefs and trust also significantly influence healthcare communication behaviour. The findings indicate that some individuals place greater trust in traditional healing systems than in formal healthcare institutions. This reflects the importance of cultural identity and belief systems in shaping health-seeking behaviour. It also suggests that healthcare communication strategies must be culturally sensitive and community-based in order to build trust and improve acceptance of health information.

Another important finding is that existing health communication interventions are often not adequately inclusive. Many health campaigns fail to consider the specific needs of marginalised populations, resulting in limited effectiveness. This highlights the need for participatory communication approaches, where communities are actively involved in the design and delivery of health messages. Community engagement is essential for improving relevance, trust, and impact of healthcare communication strategies.

Despite these challenges, the study found that radio, community outreach programmes, and interpersonal communication remain effective tools for reaching marginalised populations. These traditional communication channels are widely accessible and culturally familiar, making them important complements to digital health communication strategies. This suggests that a hybrid communication approach, combining both digital and traditional systems, may be most effective in improving health information access.

Overall, the findings demonstrate that healthcare communication inequities are multifaceted and deeply rooted in socio-economic, cultural, linguistic, and technological factors. Addressing these challenges requires integrated strategies that go beyond technological solutions to include education, policy reform, and community participation.

Conclusion

This study examined equity, inclusion, and healthcare communication with a focus on the experiences of marginalised populations in accessing health information. The findings reveal that significant inequalities persist in access to healthcare information, driven by socio-economic disadvantages, language barriers, cultural beliefs, digital exclusion, and weak healthcare communication systems.

The study established that marginalised populations often rely on informal communication channels such as community leaders, traditional healers, and interpersonal networks for health information. While these sources are accessible and culturally relevant, they may not always provide accurate or evidence-based health

information. This contributes to gaps in knowledge and may negatively affect health-seeking behaviour and outcomes.

The study also concluded that language and literacy barriers significantly hinder effective healthcare communication. Health messages delivered in non-local languages or complex formats limit understanding among marginalised groups. Similarly, digital exclusion prevents many individuals from benefiting from modern health communication tools such as online platforms, telemedicine services, and mobile health applications.

Furthermore, cultural beliefs and trust in traditional systems strongly influence how health information is received and interpreted. This highlights the importance of culturally sensitive communication strategies that respect local belief systems while promoting evidence-based health information.

The study concludes that existing healthcare communication systems are not sufficiently inclusive and often fail to address the needs of marginalised populations. As a result, health inequities are reinforced rather than reduced. However, community-based approaches such as radio programmes and outreach services remain effective in bridging communication gaps.

In conclusion, achieving equity and inclusion in healthcare communication requires a multi-dimensional approach that combines improved infrastructure, multilingual communication, digital inclusion, and community participation. Policymakers, healthcare providers, and development partners must work collaboratively to ensure that marginalised populations are not left behind in accessing essential health information.

Recommendations

Based on the findings of this study, the following recommendations are proposed:

1. Governments and health agencies should develop inclusive healthcare communication policies that prioritise marginalised populations, especially rural and low-income communities.
2. Health information should be translated into local languages and simplified formats to improve understanding among diverse population groups.
3. Community-based health communication strategies, including radio programmes, town hall meetings, and outreach campaigns, should be strengthened to reach underserved populations.
4. Investment in rural infrastructure, including electricity, internet connectivity, and mobile network coverage, should be increased to reduce digital exclusion.
5. Healthcare workers and communication officers should

be trained in culturally sensitive communication practices to improve trust and acceptance of health messages.

6. Partnerships with traditional leaders, religious institutions, and community-based organisations should be enhanced to improve the dissemination of accurate health information.
7. Digital literacy programmes should be introduced at community level to gradually integrate marginalised populations into modern health communication systems.
8. Monitoring and evaluation systems should be established to assess the effectiveness of healthcare communication strategies among marginalised groups.

Authors and Affiliations

Ayanleke Ademu
Department of Public Health
Faculty of Health Sciences
University of Ibadan
Ibadan, Oyo State, Nigeria
Email: ayanleke.ademu@ui.edu.ng

Olanisebe Sodeinde
Department of Health Promotion and Education
Faculty of Education
Obafemi Awolowo University
Ile-Ife, Osun State, Nigeria
Email: olanisebe.sodeinde@oauife.edu.ng

Grace Oluwaseyifunmi
Department of Community Health
Faculty of Allied Health Sciences
Lagos State University
Ojo, Lagos State, Nigeria
Email: grace.oluwaseyifunmi@lasu.edu.ng

Boluwatife Joshua
Department of Health Information Management
Faculty of Health Sciences
Babcock University
Ilishan-Remo, Ogun State, Nigeria
Email: boluwatife.joshua@babcock.edu.ng

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